



 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-999-4347 or visit www.hap.org. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500 person / \$1,000 family in-network: \$500 person / \$1,000 family out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care , urgent care , office visits, ambulance and emergency care are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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.
What is the out-of-pocket limit for this plan ?	\$5,000 person / \$10,000 family in- network \$10,000 person / \$20,000 family out-of- network	The out of pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , the overall family out of pocket limit must be met.
What is not included in the out-of-pocket limit ?	Premiums , Balance billing 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 .
Will you pay less if you use a network provider ?	Yes. See www.hap.org or call 1-888-999-4347 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out of network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out of network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay per visit; deductible does not apply.	50% coinsurance after deductible	Visits are face-to-face, telephonic, or through secure electronic portal
	Specialist visit	\$50 copay per visit; deductible does not apply.	50% coinsurance after deductible	-----None-----
	Other practitioner office visit	\$25 PCP Other Practitioner copay per visit/ \$50 Specialist Other Practitioner copay per visit; deductible does not apply.	50% 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 . You may have to pay for services that aren't preventive services . Ask your provider if the services needed are preventive services . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	50% coinsurance after deductible	Some services require preauthorization .
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	50% coinsurance after deductible	Services require preauthorization .
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)	10% coinsurance after deductible	50% coinsurance after deductible	Some services require preauthorization .
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	-----None-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$100 copay per visit; deductible does not apply.	\$100 copay per visit; deductible does not apply.	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency medical transportation Only
	Urgent care	\$50 copay per visit; deductible does not apply.	\$50 copay per visit; deductible does not apply.	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	50% 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 fees	10% coinsurance after deductible	50% coinsurance after deductible	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay per visit; deductible does not apply.	50% coinsurance after deductible	Some services require preauthorization . Services can be accessed by calling 1-800-444-5755
	Inpatient services	10% coinsurance after deductible	50% coinsurance after deductible	Services require preauthorization . Services can be accessed by calling 1-800-444-5755
If you are pregnant	Office visits	\$50 copay per visit; deductible does not apply	50% coinsurance after deductible	No Charge for Prenatal visits. Prenatal care not covered out of network .
	Childbirth/delivery professional services	10% coinsurance after deductible	50% coinsurance after deductible	-----None-----
	Childbirth/delivery facility services	10% coinsurance after deductible	50% coinsurance after deductible	**Some services require preauthorization .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	50% coinsurance after deductible	Up to 100 visits per Benefit Period (In-Network and Out-of-Network)
	Rehabilitation services	\$50 copay per visit; deductible does not apply	50% coinsurance after deductible	Up to 60 combined visits per benefit period- May be rendered at home (In-Network and Out-of-Network)
	Habilitation services	\$50 copay per visit; deductible does not apply	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 preauthorization . *See outpatient Mental Health for ABA cost sharing amount.
	Skilled nursing care	10% coinsurance after deductible	50% coinsurance after deductible	Up to 100 days per benefit period (In-Network and Out-of-Network)
	Durable medical equipment	10% coinsurance after deductible	50% coinsurance after deductible	Coverage provided for approved equipment based on Alliance guidelines.
	Hospice services	10% coinsurance after deductible	50% coinsurance after deductible	Up to 210 days per lifetime (In-Network and Out-of-Network)
If your child needs dental or eye care	Children's eye exam	\$50 copay per visit; deductible does not apply.	50% coinsurance after deductible	No Charge for preventive eye exam. Preventive exam not covered out-of-network
	Children's glasses	Not Covered	Not Covered	-----None-----
	Children's dental check-up	Not Covered	Not Covered	-----None-----

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care (Only if meets [plan](#) guidelines)
- Vision Hardware (Unless additional rider purchased)
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic Care
- Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue coverage after it ends. 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/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.Healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#) or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice or assistance, contact the [plan](#) at 1-800-422-4641; you may also contact the Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P.O. Box 30220, Lansing, MI 48909-7720, <http://michigan.gov/difs>; call 1-877-999-6442 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department 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 plan provide Minimum Essential Coverage? **Yes**

If you don't have [Minimum essential coverage](#) for a month, you'll have to pay when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**

If your [plan](#) doesn't meet the [Minimum value standards](#), you may be eligible for [premium tax credits](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Please see a full list of Language Access Services following the Coverage Examples at the end of the Summary of Benefits of Coverage.

_____ *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* _____

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$500
■ Specialist copayment	\$50	■ Specialist copayment	\$50	■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	10%	■ Hospital (facility) coinsurance	10%	■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%	■ Other coinsurance	10%	■ Other coinsurance	10%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$500	Deductibles	\$500	Deductibles	\$239
Copayments	\$900	Copayments	\$300	Copayments	\$350
Coinsurance	\$1,001	Coinsurance	\$186	Coinsurance	\$27
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$96	Limits or exclusions	\$4,313	Limits or exclusions	\$0
The total Peg would pay is	\$2,497	The total Joe would pay is	\$5,299	The total Mia would pay is	\$616

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



Language Access Services

VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Telefononi numrin (800) 422-4641 ose TTY: 711.

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم (800) 422-4641 أو خدمة الهاتف النصي: 711.

নজর দিন: আপনি বাংলা ভাষায় কথা বললে, ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ। (800) 422-4641 বা TTY: 711 নম্বরে কল করুন।

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 422-4641 或 TTY 用戶請致電 711。

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistentendienste zur Verfügung. Rufnummer: (800) 422-4641 oder TTY: 711.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 422-4641 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 422-4641 まで、お電話にてご連絡ください。TTY ユーザーは 711 までご連絡ください。

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-422-4641 번 또는 TTY: 711 번으로 연락해 주십시오.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 lub TTY: 711.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь по номеру (800) 422-4641 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte (800) 422-4641 ili tekstualni telefon za osobe oštećena sluha: 711.

ATENCIÓN: si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Llame al (800) 422-4641, los usuarios TTY deben llamar al 711.

تذکرہ: اگر آپ ہندی بولتے ہیں، تو ہمیں آپ کو مفت زبان کی خدمات پیش کی جاسکتی ہیں۔ (800) 422-4641 یا TTY: 711 پر رابطہ کریں۔

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Tumawag sa (800) 422-4641 o TTY: 711.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi (800) 422-4641 hoặc TTY: 711.