



Coverage for: Individual + Family | Plan Type: PPO
PP000211

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 <http://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:
<p>What is the overall deductible?</p>	<p><u>IN-NETWORK</u> \$500 individual / \$1,000 family.</p> <p><u>OUT-OF-NETWORK</u> \$500 individual / \$1,000 family.</p>	<p>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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Emergency Services, Urgent care, Emergency Medical Transportation, Rehabilitation services, Preventive services, Office Visits</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p><u>IN-NETWORK</u> \$5,000 individual/ \$10,000 family.</p> <p><u>OUT-OF-NETWORK</u> \$10,000 individual/ \$20,000 family.</p>	<p>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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

Important Questions	Answers	Why This Matters:
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.hap.org or call 1-888-999-4347 for a list of network providers.</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plans 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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



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 ; deductible does not apply	50% Coinsurance after deductible	
	Specialist visit	\$50 Copay ; deductible does not apply	50% Coinsurance after deductible	
	Other practitioner office visit	PCP Visit: \$25 Copay ; deductible does not apply Telehealth Visit: \$25 Copay ; deductible does not apply Specialist Visit: \$50 Copay ; deductible does not apply Chiropractic Visit: \$50 Copay after deductible	50% Coinsurance after deductible	Telehealth: Through our contracted telehealth services provider . Not covered Out-of- Network . Chiropractic: Manipulation of the spine for subluxation only; Up to 20 visits per benefit period (combined In and Out-Of- Network)
	Preventive care/screening/immunization	No Charge; deductible does not apply	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

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.hap.org	Preferred Generic drugs	Not Covered	Not Covered	
	Non-preferred Generic drugs	Not Covered	Not Covered	
	Preferred Brand drugs	Not Covered	Not Covered	
	Non-preferred Brand drugs	Not Covered	Not Covered	
	Preferred Specialty drugs	Not Covered	Not Covered	
	Non-preferred Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center(ASC))	10% Coinsurance after deductible	50% Coinsurance after deductible	Some services require preauthorization .
	Physician/surgeon fees	10% Coinsurance after deductible	50% Coinsurance after deductible	

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 ; deductible does not apply	\$100 Copay ; deductible does not apply	Copay will be waived if admitted
	Emergency medical transportation	No Charge; deductible does not apply	No Charge; deductible does not apply	Emergency transport only
	Urgent care	\$50 Copay ; deductible does not apply	\$50 Copay ; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance after deductible	50% Coinsurance after deductible	Some services require preauthorization .
	Physician/surgeon fees	10% Coinsurance after deductible	50% Coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 Copay ; 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 ; deductible does not apply	50% Coinsurance after deductible	Prenatal covered under Preventive Services . Prenatal not covered Out-Of-Network
	Childbirth/delivery professional services	10% Coinsurance after deductible	50% Coinsurance after deductible	
	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	Does not include Rehabilitation Services ; Up to 100 visits per benefit period (combined In and Out-of- Network).
	Rehabilitation services	\$50 Copay ; deductible does not apply	50% Coinsurance after deductible	May be rendered at home; Up to 60 combined visits per benefit period (combined In and Out-Of- Network).
	Habilitation services	\$50 Copay ; 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. Covered for authorized services only. 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 (combined In and Out-Of- Network)
	Durable medical equipment	10% Coinsurance after deductible	50% Coinsurance after deductible	Covered for approved equipment only
	Hospice services	10% Coinsurance after deductible	50% Coinsurance after deductible	Up to 210 days per lifetime (combined In and Out-of- Network)
If your child needs dental or eye care	Children's eye exam	\$50 Copay ; deductible does not apply	50% Coinsurance after deductible	One routine eye exam per benefit period at no cost share (In- Network only).
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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 Outside the U.S. | • Private Duty Nursing |
| • Routine Foot Care | • Vision Hardware | • 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) | • Voluntary Termination of Pregnancy |
|---------------------|----------------------------|--------------------------------------|

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 <http://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 1-888-999-4347; 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 <http://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 make a payment 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 a [premium tax credit](#) 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 (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic tests (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost		Total Example Cost		Total Example Cost	
	\$12,800		\$7,400		\$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	\$93
Copayments	\$900	Copayments	\$300	Copayments	\$350
Coinsurance	\$1,000	Coinsurance	\$186	Coinsurance	\$10
<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	\$2,496	The total Joe would pay is	\$5,299	The total Mia would pay is	\$453

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

