



HAP HMO Custom 2107 / Rx HMO Custom 2107

Coverage for: Individual + Family | Plan Type: HMO

AAS00191 / XRS02659

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 1-800-422-4641 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-422-4641 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0 individual / \$0 family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Out-of-Pocket Limit: \$6,350 individual/\$12,700 family	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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums , balance-billing charges, and health care this plan doesn't cover. All other cost share accumulates unless otherwise specified in Plan Documents.	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 1-800-422-4641 for a list of network providers .	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
Do you 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 .



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	\$20 Copay	Not Covered	Includes Physician home visits when Medically Necessary and Prior Authorized.
	Specialist visit	\$40 Copay	Not Covered	Includes Physician home visits when Medically Necessary and Prior Authorized.
	Other practitioner office visit	HAP Telehealth: No Charge Chiropractic Services: Not Covered	Not Covered	Telehealth: Through our designated telehealth partner.
	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)	No Charge	Not Covered	Some services require preauthorization .
	Imaging (CT/PET scans, MRIs)	\$150 Copay per test	Not Covered	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	Select Generic Drugs Tier 1	\$4 Copay / prescription (retail)	Not Covered	Costs shown apply to a 30-day supply of drugs. A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Applies to all Generic and Brand type drugs.
	Generic Drugs and Select Brand Name Drugs Tier 2	\$10 Copay / prescription (retail)	Not Covered	
	Preferred Brand Drugs Tier 3	\$40 Copay / prescription (retail)	Not Covered	
	Non-Preferred Brand and Non-Preferred Generic Drugs Tier 4	\$60 Copay / prescription (retail)	Not Covered	
	Preferred Specialty drugs Tier 5	20% Coinsurance / prescription (retail)	Not Covered	All specialty drugs are limited to a 30-day supply at a specialty pharmacy only. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a Copay or max is shown, You will pay 2 times that amount for a supply up to 60 days, and 3 times that amount for a supply of up to 90 days. Other exclusions & limitations may apply. Preferred Specialty drugs : (\$200 Max) 30 day supply.
	Non-preferred Specialty drugs Tier 6	20% Coinsurance / prescription (retail)	Not Covered	Non-Preferred Specialty drugs : (\$200 Max) 30 day supply.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center(ASC))	\$250 Copay	Not Covered	Some services require preauthorization .
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	Emergency room care	\$150 Copay	\$150 Copay	Copay will be waived if admitted
	Emergency medical transportation	\$150 Copay	\$150 Copay	Emergency transport only.
	Urgent care	\$50 Copay	\$50 Copay	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 Copay	Not Covered	Some services require preauthorization . Maximum Copay: \$500 per admission.
	Physician/surgeon fees	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 Copay	Not Covered	Some services require preauthorization . Services can be accessed by calling 1-800-444-5755.
	Inpatient services	\$100 Copay	Not Covered	Some services require preauthorization . Services can be accessed by calling 1-800-444-5755. Maximum Copay: \$500 per admission.

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 are pregnant	Office visits	No Charge	Not Covered	Routine Prenatal and Routine Postnatal covered under Preventive Services . For non-routine visits, see Specialist Visit.
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	\$100 Copay	Not Covered	Some services require preauthorization . Maximum Copay: \$500 per admission.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Does not include Rehabilitation Services . Unlimited
	Rehabilitation services	\$40 Copay	Not Covered	May be rendered at home. Up to 60 combined visits for PT,OT,ST and habilitation per benefit period.
	Habilitation services	\$40 Copay	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services for the treatment of Autism Spectrum Disorders. See Rehabilitation services for non-autism Habilitation cost sharing and limits. See Outpatient Mental Health for ABA cost sharing amount. Up to 60 combined visits for PTOTST and habilitation per benefit period.
	Skilled nursing care	No Charge	Not Covered	Covered for authorized services. Up to 730 days. Maximum benefit renews after 60 days of nonconfinement.
	Durable medical equipment	50% Coinsurance	Not Covered	Covered for approved equipment only.
	Hospice services	No Charge	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Children's eye exam	\$40 Copay	Not Covered	One routine eye exam per benefit period at no cost share.
	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
- Dental Care (Adult)
- Private Duty Nursing
- Voluntary Termination of Pregnancy
- Chiropractic Care
- Long-Term Care
- Routine Foot Care
- Cosmetic Surgery
- Non-Emergency Care Outside the U.S.
- Vision Hardware

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

- Bariatric Surgery
- Routine Eye Care (Adult)
- Hearing Aids
- Weight Loss Programs
- Infertility Treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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/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 insurance 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 <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**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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.—————

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$100
- Other [coinsurance](#) 0%

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*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$107
Coinsurance	\$0
<i>What isn't Covered</i>	
Limits or exclusions	\$61
The total Peg would pay is	\$168

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$100
- Other [coinsurance](#) 0%

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*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$865
Coinsurance	\$0
<i>What isn't Covered</i>	
Limits or exclusions	\$22
The total Joe would pay is	\$887

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$100
- Other [coinsurance](#) 0%

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	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$777
Coinsurance	\$0
<i>What isn't Covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$777

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

