




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 [www.hap.org/som](http://www.hap.org/som). 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:
<b>What is the overall <a href="#">deductible</a>?</b>	\$125 individual / \$250 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Emergency Services, <a href="#">Urgent care</a> , <a href="#">Durable Medical Equipment</a> , Lab Pathology, Chiropractic, Office Visits, <a href="#">Preventive services</a> , <a href="#">Rehabilitation Services</a> , Pharmacy.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$2,000 individual / \$4,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. All other <a href="#">cost share</a> accumulates unless otherwise specified in Plan Documents.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.hap.org">www.hap.org</a> or call 1- 800-422-4641 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">Copay</a> <a href="#">Deductible</a> does not apply	Not Covered	Includes physician home visits when <a href="#">medically necessary</a> and <a href="#">prior authorized</a> .
	<a href="#">Specialist</a> visit	\$20 <a href="#">Copay</a> <a href="#">Deductible</a> does not apply	Not Covered	Includes physician home visits when <a href="#">medically necessary</a> and <a href="#">prior authorized</a> .
	<a href="#">Preventive care/screening/immunization</a>	No Charge <a href="#">Deductible</a> does not apply	Not Covered	Coverage information available at <a href="http://www.hap.org">www.hap.org</a> . You may have to pay for services that aren't <a href="#">preventive services</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive services</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	Some services require <a href="#">preauthorization</a> . <a href="#">Deductible</a> does not apply to Laboratory Services.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Services require <a href="#">preauthorization</a> .
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.hap.org">www.hap.org</a> .	Generic drugs (Tier 1)	\$10 <a href="#">Copay</a> (retail) \$20 <a href="#">Copay</a> (mail order) <a href="#">Deductible</a> does not apply	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. Applies to all Generic and Brand type drugs.
	Preferred brand drugs (Tier 2)	\$30 <a href="#">Copay</a> (retail) \$60 <a href="#">Copay</a> (mail order) <a href="#">Deductible</a> does not apply	Not Covered	All <a href="#">specialty drugs</a> are limited to a 30-day supply at a specialty pharmacy only. Certain <a href="#">specialty drugs</a> may be approved for 60 or 90 days. In this case, if a <a href="#">copay</a> 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.
	Non-preferred brand drugs (Tier 3)	\$60 <a href="#">Copay</a> (retail) \$120 <a href="#">Copay</a> (mail order) <a href="#">Deductible</a> does not apply	Not Covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.hap.org](http://www.hap.org).

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Some services require <a href="#">preauthorization</a> .
	Physician/surgeon fees	No Charge	Not Covered	None.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 <a href="#">Copay</a> <a href="#">Deductible</a> does not apply	\$200 <a href="#">Copay</a> <a href="#">Deductible</a> does not apply	<a href="#">Copay</a> will be waived if admitted as inpatient.
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	Emergency transport only.
	<a href="#">Urgent care</a>	\$20 <a href="#">Copay</a> <a href="#">Deductible</a> does not apply	\$20 <a href="#">Copay</a> <a href="#">Deductible</a> does not apply	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require <a href="#">preauthorization</a> .
	Physician/surgeon fees	No Charge	Not Covered	None.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <a href="#">Copay</a> <a href="#">Deductible</a> does not apply	Not Covered	Some services require <a href="#">preauthorization</a> . Services can be accessed by calling 1-800- 444-5755.
	Inpatient services	No Charge	Not Covered	Some Services require <a href="#">preauthorization</a> . Services can be accessed by calling 1-800- 444-5755.
<b>If you are pregnant</b>	Office visits	No Charge <a href="#">Deductible</a> does not apply	Not Covered	Routine Prenatal and Routine Postnatal covered under <a href="#">Preventive Services</a> . For non-routine Visits see Specialist Office Visit.
	Childbirth/delivery professional services	No Charge	Not Covered	None.
	Childbirth/delivery facility services	No Charge	Not Covered	Some services require <a href="#">preauthorization</a> . Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.hap.org](http://www.hap.org).

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$20 <a href="#">Copay</a>	Not Covered	Does not include <a href="#">Rehabilitation Services</a> . Unlimited.
	<a href="#">Rehabilitation services</a>	No Charge <a href="#">Deductible</a> does not apply	Not Covered	May be rendered at home. Up to 100 combined visits per benefit period.
	<a href="#">Habilitation services</a>	No Charge <a href="#">Deductible</a> does not apply	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. Covered for authorized services only.
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	Covered for authorized services; up to 120 days per confinement
	<a href="#">Durable medical equipment</a>	No Charge <a href="#">Deductible</a> does not apply	Not Covered	Wigs – Lifetime maximum \$300
	<a href="#">Hospice services</a>	No Charge	Not Covered	Unlimited.
<b>If your child needs dental or eye care</b>	Children’s eye exam	\$20 <a href="#">Copay</a> <a href="#">Deductible</a> does not apply	Not Covered	One routine eye exam per benefit period at no <a href="#">cost share</a> .
	Children’s glasses	Not Covered	Not Covered	None.
	Children’s dental check-up	Not Covered	Not Covered	None.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.hap.org](http://www.hap.org).

## 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)
- Non-Emergency Care Outside of the U.S.
- Cosmetic Surgery
- Long-Term Care
- Routine Foot Care

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

- Bariatric Surgery – One Procedure per lifetime
- Chiropractic Care – Manipulations only, up to 24 visits per plan year
- Hearing Aids – One (1) Hearing Aid per ear per plan year
- Infertility Treatment – Coverage includes diagnosis, counseling, and treatment of infertility when medically necessary and preauthorized by HAP. One attempt of artificial insemination per lifetime.
- Private Duty Nursing – Medically necessary care, limited to 90 days per plan year
- Routine Eye Care (Adult) – One routine eye exam per plan year
- Weight Loss Programs – HAP approved multidisciplinary program when meeting age/BMI criteria

**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](http://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](http://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](mailto: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 the 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](#).

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.hap.org](http://www.hap.org).



## Language Assistance

We want you to easily get the information you need. To request assistance in a language other than English, call (800) 422-4641 (TTY: 711).

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.

800) 422-4641 (TTY: 711) 4641 711 TTY.

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.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$125
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility)	\$0
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$125
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$61
<b>The total Peg would pay is</b>	<b>\$196</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$125
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility)	\$0
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$724
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$22
<b>The total Joe would pay is</b>	<b>\$746</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$125
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility)	\$0
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$125
<a href="#">Copayments</a>	\$265
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$390</b>

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