HAP 2500 Silver

Coverage for: Self-Only Family | **Plan Type: PPO HSA**

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 1-800-944-9399 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 1-888-944-9399 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$2,500** self-only / **$5,000** family. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. Out-of-Network: **$5,000** self-only / **$10,000** family, not to exceed **$5,000** from any one person.	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, routine eye exam and vision hardware is covered before you meet your In Network 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?	In-Network: **$5,000** self-only coverage / **$10,000** family coverage, not to exceed **$5,000** from any one person. Out-of-Network: None	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 limit until the overall family out of pocket limit has been 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.hap.org or call 1-800-944-9399** 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	20% coinsurance after deductible	50% coinsurance after deductible	----------None----------
	Specialist visit	20% coinsurance after deductible	50% coinsurance after deductible	----------None----------
	Other practitioner office visit	PCP Other Practitioner/ Specialist Other Practitioner: 20% coinsurance after deductible Telehealth: 20% coinsurance after deductible	50% coinsurance after deductible	Chiropractic manipulation of the spine for subluxation only. 20% coinsurance after deductible. 20 visits per benefit year. Acupuncture Not Covered. Telehealth services not covered out-of-network
	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)	20% coinsurance after deductible	50% coinsurance after deductible	* Some services require preauthorization.
	Imaging (CT/PET scans, MRIs)	20% 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	Generic drugs	Preferred and Non-Preferred: 20% coinsurance after deductible	Not Covered	Preauthorization required for non-formulary drugs, including non-formulary contraceptives at no cost sharing & brand drugs that have a generic equivalent available (applies to all drug categories). Retail: 30 day supply; Mail Order: 90 day supply
	Preferred brand drugs	20% coinsurance after deductible	Not Covered	Same as Generic Drugs above.
	Non-preferred brand drugs	20% coinsurance after deductible	Not Covered	Same as Generic Drugs above.
	Specialty drugs	Preferred and Non-Preferred: 20% coinsurance after deductible	Not Covered	Up to a 30 day supply covered at specialty pharmacy only. Specialty drugs not available at 90 day or mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	Some services require preauthorization.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	----------None----------
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	----------None----------
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Emergency medical transportation Only
	Urgent care	20% coinsurance after deductible	20% coinsurance after deductible	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% 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	20% 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 mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755
	Inpatient services	20% 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	20% coinsurance after deductible	50% coinsurance after deductible	----------None----------
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	No Charge for Prenatal visits. Prenatal care not covered out of network.
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	**Some services require preauthorization.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	----------None----------
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Physical Therapy and Occupational Therapy up to 30 combined visits per benefit period. Speech Therapy up to 30 visits per benefit period. Services may be rendered in the home. (Combined In-Network and Out-of-Network)
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Physical Therapy and Occupational Therapy up to 30 combined visits per benefit period. Speech Therapy up to 30 visits per benefit period. Services may be rendered in the home. (Combined In-Network and Out-of-Network)
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Up to 45 days per benefit period (combined in and out of network)
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Coverage provided for approved equipment based on Alliance guidelines. Some services require preauthorization.
	Hospice services	20% 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 your child needs dental or eye care	Children's eye exam	20% coinsurance after deductible	50% coinsurance after deductible	One routine eye exam per benefit period at no cost share. Routine exam not covered out-of-network.
	Children's glasses	No Charge	Not Covered	Coverage for one pair of eye glasses each year. Detailed information regarding coverage of lenses and Collection Frames can be found in your policy or plan documents. No coverage for Adult Vision Hardware.
	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
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Voluntary Abortion

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

- Bariatric Surgery (Only if meets plan guidelines)
- Chiropractic Care
- Infertility Treatment (Only if meets plan guidelines)
- Routine Eye Care (Adult)
- Routine Foot Care (Only if meets plan guidelines)
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue coverage after it ends. For more information on you rights to continue coverage, contact the plan at 1-800-944-9399; 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)

The plan's overall deductible	$2,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,060

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

The plan's overall deductible	$2,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$1,437
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$3,992

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

The plan's overall deductible	$2,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,540
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,925

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 4641-422 (800) 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 用户請致電 711。

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste 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.

ܙܘܗܪܐ: ܐܢ ܐܢܫܬܘܢ ܟܐ ܡܗܓܝܓܝܬܘܢ ܠܗ ܠܫܢܐ ܐܣܘܪܝܝܐ\ܟܠܕܝܐ، ܟܝ ܒܥܬܘܢ ܕܩܒܠܝܬܘܢ ܚܠܡܬܐ ܡܓܢܝܬܐ ܕܥܘܕܪܢܐ ܕܠܫܢܐ ܒܩܪܝܬܐ ܠܓܠ ܡܢܝܢܐ (800) 422-4641 ܝܢ ܠܓܠ TTY: 711.

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.