HAP HMO Custom 2145 / Rx HMO Custom 2145w **Coverage for: Individual + Family | Plan Type: HMO**

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?	**$750** individual / **$1,500** family.	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.
Are there services covered before you meet your deductible?	Yes. Emergency Services, Urgent care, Chiropractic, Office Visits, Preventive services, Pharmacy	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.
What is the out-of-pocket limit for this plan?	**Coinsurance Maximum:** **$1,000** individual/ **$2,000** family; does not apply to deductible. **Out-of-Pocket Limit:** **$6,600** individual/ **$13,200** 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.
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.

Important Questions	Answers	Why This Matters:
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	$30 Copay; deductible does not apply	Not Covered	
	Specialist visit	$40 Copay; deductible does not apply	Not Covered	
	Other practitioner office visit	Telehealth Visit: $30 Copay; deductible does not apply Chiropractic Visit: $40 Copay; deductible does not apply	Not Covered	Telehealth: Through our contracted telehealth services provider. Chiropractic: Manipulation of the spine for subluxation only. Up to 24 visits per benefit period.
	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)	15% Coinsurance after deductible	Not Covered	Some services require preauthorization
	Imaging (CT/PET scans, MRIs)	15% Coinsurance after deductible	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	Preferred Generic drugs	$10 Copay / prescription (retail); deductible 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. Other exclusions & limitations may apply. Applies to all Generic and Brand type drugs.
	Non-preferred Generic drugs	$10 Copay / prescription (retail); deductible does not apply	Not Covered	
	Preferred Brand drugs	$30 Copay / prescription (retail); deductible does not apply	Not Covered	
	Non-preferred Brand drugs	$50 Copay / prescription (retail); deductible does not apply	Not Covered	
	Preferred Specialty drugs	10% Coinsurance / prescription (retail); deductible does not apply	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: ($100 Max) 30 day supply.
	Non-preferred Specialty drugs	15% Coinsurance / prescription (retail); deductible does not apply	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))	15% Coinsurance after deductible	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	15% Coinsurance after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	$200 Copay; deductible does not apply	$200 Copay; deductible does not apply	Copay will be waived if admitted
	Emergency medical transportation	15% Coinsurance after deductible	15% Coinsurance after deductible	Emergency transport only
	Urgent care	$40 Copay; deductible does not apply	$40 Copay; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% Coinsurance after deductible	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	15% Coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay; deductible does not apply	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755.
	Inpatient services	15% Coinsurance after deductible	Not Covered	Services require preauthorization. Services can be accessed by calling 1-800-444-5755.
If you are pregnant	Office visits	$40 Copay; deductible does not apply	Not Covered	Prenatal covered under Preventive Services.
	Childbirth/delivery professional services	15% Coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	15% Coinsurance after deductible	Not Covered	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	15% Coinsurance after deductible	Not Covered	Does not include Rehabilitation Services. Unlimited.
	Rehabilitation services	15% Coinsurance after deductible	Not Covered	May be rendered at home. Up to 60 combined visits per benefit period.
	Habilitation services	15% Coinsurance after deductible	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	15% Coinsurance after deductible	Not Covered	Covered for authorized services. Up to 730 days. Maximum benefit renews after 60 days of nonconfinement.
	Durable medical equipment	15% Coinsurance after deductible	Not Covered	Covered for approved equipment only
	Hospice services	15% Coinsurance after deductible	Not Covered	Up to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	$40 Copay; deductible does not apply	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
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care Outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- Vision Hardware
- Voluntary Termination of Pregnancy

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

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

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.

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**	**$750**	■ **The plan's overall deductible**	**$750**	■ **The plan's overall deductible**	**$750**
■ **Specialist copayment**	**$40**	■ **Specialist copayment**	**$40**	■ **Specialist copayment**	**$40**
■ **Hospital (facility) coinsurance**	**15%**	■ **Hospital (facility) coinsurance**	**15%**	■ **Hospital (facility) coinsurance**	**15%**
■ **Other coinsurance**	**15%**	■ **Other coinsurance**	**15%**	■ **Other coinsurance**	**15%**
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	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$750	Deductibles	$750	Deductibles	$750
Copayments	$10	Copayments	$844	Copayments	$325
Coinsurance	$1,772	Coinsurance	$24	Coinsurance	$144
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$61	Limits or exclusions	$22	Limits or exclusions	$0
The total Peg would pay is	**$2,593**	**The total Joe would pay is**	**$1,640**	**The total Mia would pay is**	**$1,219**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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.

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