: State of Michigan Actives, Group 10000623

Coverage for: Individual or 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 <u>www.hap.org</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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? | \$125 individual / \$250 family | Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. Emergency Services, <u>Urgent care</u> , <u>Durable Medical Equipment</u> , Lab Pathology, Chiropractic, Office Visits, <u>Preventive services</u> , <u>Rehabilitation</u> <u>Services</u> , Pharmacy. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | \$2,000 individual / \$4,000 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> 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 <u>network provider</u> ? | Yes. See www.hap.org or call 1- 800-422-4641 for a list of network providers . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | Yes | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |

| Common Medical Event | Services You May Need | What You Network Provider (You will pay the least) | u Will Pay Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|--|
| | Primary care visit to treat an injury or illness | \$20 <u>Copay</u> <u>Deductible</u> does not apply | Not Covered | Includes physician home visits when Medically Necessary and Prior Authorized. |
| If you visit a health care | Specialist visit | \$20 <u>Copay</u> <u>Deductible</u> does not apply | Not Covered | Includes physician home visits when Medically Necessary and Prior Authorized. |
| provider's office or clinic | 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) | No Charge | Not Covered | Some services require <u>preauthorization</u> . <u>Deductible</u> does not apply to Laboratory Services. |
| | Imaging (CT/PET scans, MRIs) | No Charge | Not Covered | Services require preauthorization. |
| If you need drugs to | Generic drugs (Tier 1) | \$10 <u>Copay</u> (retail) \$20 <u>Copay</u> (mail order) <u>Deductible</u> does not apply | Not Covered | Retail 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. |
| treat your illness or condition More information about prescription drug coverage is available at www.hap.org. | Preferred brand drugs (Tier 2) | \$30 <u>Copay</u> (retail) \$60 <u>Copay</u> (mail order) <u>Deductible</u> 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 |
| | Non-preferred brand drugs (Tier 3) | \$60 <u>Copay</u> (retail) \$120 <u>Copay</u> (mail order) <u>Deductible</u> does not apply | Not Covered | 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. |

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.hap.org</u>.

| | | What You Will Pay | | | |
|--|--|--|--|---|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
| If you have outpatient | Facility fee (e.g., ambulatory surgery center) | No Charge | Not Covered | Some services require <u>preauthorization</u> . | |
| surgery | Physician/surgeon fees | No Charge | Not Covered | None. | |
| | Emergency room care | \$200 <u>Copay</u> <u>Deductible</u> does not apply | \$200 <u>Copay</u> <u>Deductible</u> does not apply | Copay will be waived if admitted as inpatient. | |
| If you need immediate medical attention | Emergency medical transportation | No Charge | Not Covered | Emergency transport only. | |
| | <u>Urgent care</u> | \$20 <u>Copay</u> <u>Deductible</u> does not apply | \$20 <u>Copay</u> <u>Deductible</u> does not apply | None. | |
| If you have a hospital | Facility fee (e.g., hospital room) | No Charge | Not Covered | Some services require <u>preauthorization</u> . | |
| stay | Physician/surgeon fees | No Charge | Not Covered | None. | |
| If you need mental health, behavioral | Outpatient services | \$20 <u>Copay</u> <u>Deductible</u> does not apply | Not Covered | Some services require <u>preauthorization</u> . Services can be accessed by calling 1-800- 444-5755. | |
| health, or substance abuse services | Inpatient services | No Charge | Not Covered | Services require <u>preauthorization</u> . Services can be accessed by calling 1-800- 444-5755. | |
| If you are pregnant | Office visits | No Charge Deductible does not apply | Not Covered | Cost sharing does not apply for preventive services. Depending on the type of services, copay or deductible may apply. | |
| | Childbirth/delivery professional services | No Charge | Not Covered | Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). Prenatal covered under | |
| | Childbirth/delivery facility services | No Charge | Not Covered | Preventive Services. Some services require preauthorization. | |

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.hap.org</u>.

| | | What You Will Pay | | Limitations, Exceptions, & Other |
|---|----------------------------|---|---|---|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Important Information |
| If you need help recovering or have other special health needs | Home health care | \$20 <u>Copay</u> | Not Covered | Does not include Rehabilitation Services. Unlimited. |
| | Rehabilitation services | No Charge Deductible does not apply | Not Covered | May be rendered at home. Up to 100 combined visits per benefit period. |
| | Habilitation services | No Charge <u>Deductible</u> 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 | No Charge | Not Covered | Covered for authorized services; up to 120 days per confinement |
| | Durable medical equipment | No Charge Deductible does not apply | Not Covered | Wigs – Lifetime maximum \$300 |
| | Hospice services | No Charge | Not Covered | Unlimited. |
| If your child needs dental or eye care | Children's eye exam | \$20 <u>Copay</u> <u>Deductible</u> does not apply | Not Covered | One routine eye exam per benefit period at no cost share. |
| | 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 $\underline{\text{plan}}$ or policy document at $\underline{\text{www.hap.org}}$.

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

Infertility Treatment

• Routine Eye Care (Adult)

Chiropractic Care

Private Duty Nursing

Weight Loss Programs

Hearing Aids

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 <u>plan</u> 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.tealthcare.gov 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/difs.

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 <u>plan</u> or policy document at <u>www.hap.org</u>.

Language Access 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.

تتبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساحدة اللغوية مجانًا. اتصل بالرقم 4641-422 (800) أو خدمة الهاتف النصبي: 711.

নজর দিন: আপনি বাংলা ভাষায় কথা বললে, ভাষা সহায়ভার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ। (৪০০) 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.

ردد) کے بیرون کے مورومیلان کے اور ایک کی میں ایک کی ایک 4641 کے 11 :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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.hap.org</u>.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u> | \$125 |
|---|-------|
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) | \$0 |
| ■ Other <u>coinsurance</u> | 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: | | |
| Cost Sharing | | |
| <u>Deductibles</u> | \$125 | |
| Copayments | \$10 | |
| Coinsurance | \$0 | |
| What isn't covered | | |
| Limits or exclusions | \$61 | |
| The total Peg would pay is | \$196 | |

Managing Joe's Type 2 Diabetes

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

| ■ The <u>plan's</u> overall <u>deductible</u> | \$125 |
|---|-------|
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) | \$0 |
| ■ Other <u>coinsurance</u> | 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: | | |
| Cost Sharing | | |
| <u>Deductibles</u> | \$0 | |
| Copayments | \$724 | |
| Coinsurance | \$0 | |
| What isn't covered | | |
| Limits or exclusions | \$22 | |
| The total Joe would pay is | \$746 | |

Mia's Simple Fracture

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

| ■ The <u>plan's</u> overall <u>deductible</u> | \$125 |
|---|-------|
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) | \$0 |
| ■ Other <u>coinsurance</u> | 0% |

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

| Total Example Cost | \$2,800 |
|---------------------------------|---------|
| In this example, Mia would pay: | |
| Cost Sharing | |
| <u>Deductibles</u> | \$125 |
| Copayments | \$265 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$390 |