Genesee HEALTH SYSTEM
Hope and health in the community

MAIN CAMPUS
420 W. Fifth Avenue
Flint, MI 48503
Phone: (810) 257-3705
Toll Free: (866) 211-5455
Crisis Line: (877) 346-3648
www.genhs.org

September 27, 2023

RE: Non-Medicare Retiree Options

Retiree Open Enrollment is under way 11/6/2023 through 11/22/2023.

Retirees who do not need to make changes: For the 2024 Plan Year, GHS will not require retirees to complete the annual open enrollment packet unless making a change to a medical, dental or vision plan**. If there are no changes, nothing is required of you.**

Retirees who need to make changes: Open Enrollment information and other reference documents are listed on the GHS website at www.genhs.org - CMH/GHS Retirees tab near the bottom of the page. **If you need enrollment assistance, you may reach out to Benefits by email (benefits@genhs.org) or phone (810) 347-7408.**

Please note, GHS will continue to offer the Health Alliance Plan (HAP) High Deductible Health Plan HMO (HAP HDHP HMO) and Health Alliance Plan High Deductible Health Plan PPO (HAP HDHP PPO) for the 2024 enrollment year. **Deductibles for the 2024 enrollment year are $1600 for a single, and $3200 for a double or family.** Dental and Vision coverage options remain the same as in 2023.

If you or your spouse will be eligible for Medicare in 2024, Benefits will reach out to you at the appropriate time and assist you with the change in enrollment.

Please keep in mind that the **Open Enrollment period is 11/6/2023 thru 11/22/2023.** If you need to make changes, please do so on or before **November 22, 2023.** We have provided additional information on the GHS retiree website which you may find informative and beneficial, in addition to enrollment forms and other reference documents. Dental and Vision coverage options remain the same as in 2023. As a final reminder, if you will be eligible for an HSA contribution, your HSA account must be open and active.

Please direct any questions or concerns, to benefits@genhs.org, **or reach out directly at (810) 347-7408**.

Sincerely,

Sandra Sweet

Sandra Sweet, Accounting Manager
Genesee Health System

GENESEE HEALTH SYSTEM

Retiree Under 65– Retired Prior to 11/20/2007

2024 INSURANCE ENROLLMENT

Enrollment/Change Status: Open Enrollment ☐ Other Period ☐

Retiree Name:	Social Security #			
Address:	Telephone #			
City, State ZIP:	Date of Birth			

MEDICAL INSURANCE OPTIONS ***HAP=Health Alliance Plan***	**Single**	**Two-Party**	**Family**	Effective Date:	GHS Initials
*HAP High Deductible Health Plan (PPO)	☐	☐	☐	(For Official Use Only)	
*HAP High Deductible Health Plan (HMO) (**Base Plan** is HMO version)	☐	☐	☐		
OPTICAL/DENTAL INSURANCE					
Blue Cross Blue Shield of Michigan	☐	☐	☐	Effective Date:	GHS Initials:
Delta Dental of Michigan	☐	☐	☐	Effective Date:	GHS Initials

CONTRACT CONTINUATION □ ***ADDITION*** □ ***DELETION*** □

Last Name (Print)	**First Name**	**Relation**	**F/M**	**SSN**			**DOB**	**Primary Care Physician**
		SELF						
		SPOUSE						
		DEPEND						
		DEPEND						

Please Note: Initial spouse and dependent coverage is subject to verification of eligibility. Eligibility documents include a copy of marriage license and social security card for spouse; and birth certificate and social security card for dependent. Provisions and penalties described in the "No Dual Hospital/Medical Coverage Certification" form apply. Please see the CMH/GHS Retiree Options document included in the packet for further explanation of insurance selections.

I certify that I have read and understand the information on this form. The statements and answers given are complete and correct to the best of my knowledge and belief. No information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the insurance carriers will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made false statements or misrepresentations, or have failed to disclose any material fact, the carriers will be entitled to declare the health care contract void and refuse all allowance of the benefits to any person under the contract. I understand that anyone listed above, seeking enrollment into a GHS sponsored health plan is prohibited from being enrolled in any other hospital/medical coverage, including Medicare.

Please contact benefits at benefits@genhs.org or (810) 347-7408 for questions.

Retiree's Signature (Do Not Print)	Date	Employer's Signature	Date

NO DUAL HOSPITAL / MEDICAL COVERAGE CERTIFICATION

I have exercised my option to enroll in one of the Genesee Health System sponsored Hospital/Medical Plans. I understand that anyone enrolled in a High Deductible Health Plan (HDHP) covered under a Health Savings Account (HSA) is prohibited from participating in the plan if any one of those enrolled has other hospital/medical insurance. All enrollees are prohibited from having dual hospital/medical insurance due to federal requirements for participation in a HDHP w/ HSA. In addition, GHS prohibits retirees and anyone else on their hospital/medical policy from maintaining dual insurance coverage. Medicare Part A and/or Part B are still considered dual insurance unless enrolled into a Medicare Advantage (MA) plan sponsored by GHS. It is the responsibility of the retiree to notify GHS benefits personnel within 30-days of being eligible or enrolled into Medicare, and provide this information annually during the annual open enrollment period. Failure to notify GHS of your (or your family members') Medicare eligibility and/or enrollment could result in negative federal tax implications for the retiree.

In accordance with the GHS prohibition against dual hospital/medical coverage, I hereby certify that neither I, my spouse, nor any dependent under age 19, nor any qualified adult child aged 19-26 listed on the enrollment application form have any other hospital/medical coverage. Regarding the possible enrollment of a qualified adult child aged 19-26, the child is governed by the rules associated with plans which qualify to be "grandfathered" or "not grandfathered". I also understand that if I have failed to disclose or falsified documentation regarding this paragraph, that GHS will bill me the amount overpaid by GHS for myself, spouse, dependent or qualified adult child aged 19-26 that was inappropriately dual covered. Falsification of documents constitutes fraud and is subject to termination.

I understand that GHS will require documentation of involuntary termination of coverage if I am transferring either my spouse, dependent, or qualified adult child aged 19-26 to a GHS hospital/medical plan from another employer paid source, outside the GHS open enrollment period.

I understand that I must notify GHS benefits personnel within 30 days of any qualifying event, which would require a spouse, dependent, or qualified adult child aged 19-26 to be removed from my insurance. I also understand that if I do not comply with this rule that GHS will bill me the amount overpaid by GHS for a spouse, dependent, or qualified adult child aged 19-26 that should have been removed from my insurance. Charges will become effective as of the last day of the month in which the qualifying event occurs.

I understand that I must notify GHS benefits personnel within 30 days of any qualifying event, which would require a spouse, dependent, or qualified adult child aged 19-26 to be added to my insurance. I also understand that if I do not comply with this rule, the spouse, dependent, or qualified child aged 19-26 must wait until the GHS open enrollment period to be added to my insurance. If adult child is eligible to enroll in your group hospital/medical health plan, then coverage <u>will terminate on the last day of the month in which the child turns 26</u>, or child becomes otherwise ineligible.

_____
Name Printed

_____ _____ _____
Signature Date GHS INITIALS

Designation of Beneficiary Form

Employer/Group Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk(*).)

*Employer/Group Name: Genesee Health System	Group ID: G000B2R2

Employee/Member Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name:	*First Name:	MI:
*Social Security Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:
*Street Address:	Email Address:
*City:	*State:	*ZIP Code:	Telephone: ( ) -

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Agreement and Signature

I understand that this Designation of Beneficiary shall apply to all insurance contracts issued to me by Mutual of Omaha or a company affiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this designation. I also understand that this Designation of Beneficiary is subject to change as provided in the group contract(s).

By signing below, I acknowledge that (a) I understand and agree to the terms of this form as noted above; and (b) this Designation of Beneficiary is effective as of the date submitted.

SIGNATURE OF EMPLOYEE/MEMBER _____ **DATE**_____/_____/_____

CMH/GHS RETIREE OPTIONS

2024 Retiree Healthcare Enrollment Drives Options Available to Spouse

IMPORTANT - Please read carefully! As a Retiree from CMH/GHS, you are the reason and the *pathway* for your potentially eligible spouse and/or child(ren) to enroll in a GHS sponsored healthcare plan. The selection of a healthcare plan made by the Retiree *drives the options* an eligible spouse/child might be enrolled into. What follows are several examples of healthcare enrollment decisions a Retiree might make and the corresponding result of that decision for their spouse/child as potential enrollees via GHS sponsored plans:

Please Note that HAP Medicare Advantage plans only provide coverage (other than emergency services) in Michigan.

Retiree Under 65 Non-Medicare Eligible; w/ Spouse Under 65 Non-Medicare Eligible

- Retiree elects ***HAP HDHP HMO**, spouse may only enroll in **HAP HDHP HMO** version
- Retiree elects ****HAP HDHP PPO***, spouse may only enroll in ***HAP HDHP PPO*** version

Both under 65 Non-Medicare; Must be enrolled into the **same** Health Alliance Plan

Retiree Under 65 Non-Medicare Eligible; w/ Spouse 65+ Medicare Eligible

- Retiree elects **HAP HDHP HMO**, spouse may only enroll in **HAP MA HMO** version or *****BC-MA**
- Retiree elects **HAP HDHP PPO**, spouse may only enroll in **HAP MA PPO** version or **BC-MA**

Retiree Over 65 Medicare Eligible; w/ Spouse Under 65 Non-Medicare Eligible

- Retiree elects **HAP MA HMO or BC-MA**, spouse may only enroll in **HAP HDHP HMO** version
- Retiree elects **HAP MA PPO or BC-MA**, spouse may only enroll in **HAP HDHP PPO** version

Retiree Over 65 Medicare Eligible; w/ Spouse Over 65 Medicare Eligible

- Retiree elects **HAP MA HMO**, spouse may only enroll in **HAP MA HMO** version
- Retiree elects **HAP MA PPO**, spouse may only enroll in **HAP MA PPO** version
- Retiree elects **BC-MA**, spouse may only enroll in **BC-MA**

Both Medicare Eligible (Retiree and Spouse); Must be enrolled into the **same** plan design selected by the retiree

If you have any questions or concerns, you may contract:
Benefits (benefits@genhs.org) or phone (810) 347-7408 or fax (810) 496-5767

*Health Alliance Plan High Deductible Health Plan HMO
**Health Alliance Plan High Deductible Health Plan PPO
***Blue Cross Blue Shield Medicare Plus Blue Group

Healthcare Options

Under "65" Retirees
Retired Prior to 11/20/2007

January 1, 2024 - December 31, 2024

Benefit	HAP HDHP PPO	HAP HDHP HMO
Deductible	$1,600 Single/$3,200 Double, Family (Agency to fund into HSA Account $1,150 Single; or $2,300 Family)	$1,600 Single/$3,200 Double, Family (Agency to fund into HSA Account $1,400 Single; or $2,800 Family)
Co-insurance (after deductible is met)	$1,000 per single or $2,000 per family	$1,000 per single or $1,000 per family (Agency to Reimburse 80% of Expenses)
Prescription Co-pay	$10 Generic / $50 Brand (After Deductible is met)	$10 Generic / $50 Brand (After Deductible is met)
Office Co-pay	$25 co-pay (After Deductible is met)	$15 co-pay (After Deductible is met)
Comments Questions? Please call 810-496-5603		Must reside in Michigan and receive Primary Care services in the 20 county service area.

HEALTHCARE ENROLLMENT CHECKLIST
Non Medicare Retiree-Retired Prior to 11/20/2007

Please note the following deductibles apply to the HAP HD HMO and PPO Plans:
Individual Plan/$1,600
Family Plan/$3,200

If you are making no changes to healthcare:

☐ For the 2024 plan year, GHS will not require retirees to complete the annual open enrollment packet unless making a change.

If you are changing your healthcare plan:

☐ Complete the enclosed, blank GHS Enrollment Form in its entirety (available on the GHS Retiree website)

Attach a copy of the applicable items listed below:

- ☐ "No Dual Hospital/Medical Coverage Certification" form – Signed
- ☐ Completed Mutual of Omaha Beneficiary Form
- ☐ Marriage Certificate
- ☐ Birth Certificates & Social Security cards of dependents

Please return all required documentation by **Wednesday, November 22, 2023.**

You can contact the GHS Benefits Department with any questions

Benefits
Genesee Health System
420 W. Fifth Avenue 2nd Floor, Flint, MI 48503
Phone 810.347-7408 Fax 810.496.5767

Administered by Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company (Alliance)
Self-Funded Health Maintenance Organization (HMO) Plan
Summary of Benefits
AS000118 / XR003081 **Self-Funded HMO**

AS000118 / XR003081

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,600 Self Only; $3,200 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	10%	N/A	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$2,600 Self Only; $4,200 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	N/A	These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$15 Copay after deductible	N/A	
Telehealth Visit	$15 Copay after deductible	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$15 Copay after deductible	N/A	
Routine Audiology Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	10% Coinsurance after deductible	N/A	Manipulation of the spine for subluxation only. Up to 10 visits per benefit period.
Allergy Treatment	10% Coinsurance after deductible	N/A	
Allergy Injections	10% Coinsurance after deductible	N/A	
Laboratory & Pathology	10% Coinsurance after deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	10% Coinsurance after deductible	N/A	Services require preauthorization.
Radiology (X-ray)	10% Coinsurance after deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	10% Coinsurance after deductible	N/A	
Dialysis	10% Coinsurance after deductible	N/A	
Outpatient Medical Drugs	10% Coinsurance after deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	10% Coinsurance after deductible	N/A	
Ambulatory Surgical Center	10% Coinsurance after deductible	N/A	
Professional Surgical and Related Services	10% Coinsurance after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$50 Copay after deductible		
Emergency Room Care	$100 Copay after deductible		Copay will be waived if admitted
Emergency Medical Transportation	10% Coinsurance after deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	10% Coinsurance after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	10% Coinsurance after deductible	N/A	
Bariatric Surgery and Related Services	10% Coinsurance after deductible	N/A	One procedure per lifetime

Maternity Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services
Routine Postnatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$15 Copay after deductible	N/A	
Other Services			
Home Health Care	10% Coinsurance after deductible	N/A	Does not include Rehabilitation Services. Up to 60 visits per benefit period.
Hospice Care	10% Coinsurance after deductible	N/A	Up to 210 days per lifetime.
Skilled Nursing Care	10% Coinsurance after deductible	N/A	Covered for authorized services.Up to 730 days. Maximum benefit renews after 60 days of nonconfinement.
Durable Medical Equipment; Prosthetics & Orthotics	50% Coinsurance after deductible	N/A	Covered for approved equipment only.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	10% Coinsurance after deductible	N/A	May be rendered at home. Up to 60 combined visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	10% Coinsurance after deductible	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	$15 Copay after deductible	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy.
Voluntary Termination of Pregnancy	See Outpatient Surgical Services	N/A	During first trimester only. Limited to 1 within a 24 month period.
Infertility Services	50% Coinsurance after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	50% Coinsurance after deductible	N/A	One attempt per lifetime.
Temporomandibular Joint Disorder	10% Coinsurance after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply after deductible		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Non-Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply after deductible		
Preferred Brand Drugs	$50 Copay 30 day supply, $100 Copay 90 day supply after deductible		
Non-Preferred Brand Drugs	$50 Copay 30 day supply, $100 Copay 90 day supply after deductible		
Preferred Specialty Drugs	$50 Copay 30 day supply at specialty pharmacy only after deductible		
Non-Preferred Specialty Drugs	$50 Copay 30 day supply at specialty pharmacy only after deductible		
Infertility Drugs	50% Coinsurance 30 day supply only after deductible		

- In case of conflict between this summary and your Self-Funded HMO Benefit Guide, the terms and conditions of the Self-Funded HMO Benefit Guide will govern.
- Elective hospital admissions require that Alliance be notified prior to the admission. Alliance must be notified within 48 hours after an emergency hospital admission. Failure to notify Alliance could result in a reduction or denial of benefits.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.
- Students away at school are covered for acute illness and injury related services according to Alliance criteria.
- Self-Funded HMO plans are administered by Alliance Health and Life Insurance Company, a wholly owned subsidiary of Health Alliance Plan.
-For Outpatient Mental Health & Substance Use Disorder Services delivered via Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the Telehealth Cost-Share.

Alliance Health and Life Insurance Company **AS000118 / XR003081**

Coverage for: Individual + Family | Plan Type: ASO HMO QHDHP

AS000118 XR003081

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?	**$1,600** self only coverage / **$3,200** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. some Office Visits, Preventive services	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?	**Out-of-Pocket Limit:** **$2,600** self only coverage / **$4,200** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	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, the overall family out-of-pocket limit must be 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.hap.org or call 1-800-422-4641 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	$15 Copay after deductible	Not Covered	
	Specialist visit	$15 Copay after deductible	Not Covered	
	Other practitioner office visit	Telehealth Visit: $15 Copay after deductible Chiropractic Visit: 10% Coinsurance after deductible	Not Covered	Telehealth: Through our contracted telehealth services provider. Chiropractic: Manipulation of the spine for subluxation only. Up to 10 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)	10% Coinsurance after deductible	Not Covered	Some services require preauthorization
	Imaging (CT/PET scans, MRIs)	10% 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) after deductible	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. Infertility Drug: 50% Coinsurance
	Non-preferred Generic drugs	$10 Copay / prescription (retail) after deductible	Not Covered	
	Preferred Brand drugs	$50 Copay / prescription (retail) after deductible	Not Covered	
	Non-preferred Brand drugs	$50 Copay / prescription (retail) after deductible	Not Covered	
	Preferred Specialty drugs	$50 Copay / prescription (retail) after deductible	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.
	Non-preferred Specialty drugs	$50 Copay / prescription (retail) after deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center(ASC))	10% Coinsurance after deductible	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	10% Coinsurance after deductible	Not Covered	

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 immediate medical attention	Emergency room care	$100 Copay after deductible	$100 Copay after deductible	Copay will be waived if admitted
	Emergency medical transportation	10% Coinsurance after deductible	10% Coinsurance after deductible	Emergency transport only
	Urgent care	$50 Copay after deductible	$50 Copay after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance after deductible	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	10% Coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 Copay after deductible	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755.
	Inpatient services	10% Coinsurance after deductible	Not Covered	Services require preauthorization. Services can be accessed by calling 1-800-444-5755.
If you are pregnant	Office visits	No Charge; deductible does not apply	Not Covered	Routine Prenatal and Routine Postnatal covered under Preventive Services.
	Childbirth/delivery professional services	10% Coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	10% 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	10% Coinsurance after deductible	Not Covered	Does not include Rehabilitation Services. Up to 60 visits per benefit period.
	Rehabilitation services	10% Coinsurance after deductible	Not Covered	May be rendered at home. Up to 60 combined visits per benefit period.
	Habilitation services	10% 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	10% Coinsurance after deductible	Not Covered	Covered for authorized services. Up to 730 days. Maximum benefit renews after 60 days of nonconfinement.
	Durable medical equipment	50% Coinsurance after deductible	Not Covered	Covered for approved equipment only
	Hospice services	10% Coinsurance after deductible	Not Covered	Up to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	$15 Copay after deductible	Not Covered	One exam per benefit period. For non-routine visits see Specialist Office Visit.
	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

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)	• Voluntary Termination of Pregnancy	• 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**	**$1,600**	■ **The plan's overall deductible**	**$1,600**	■ **The plan's overall deductible**	**$1,600**
■ **Specialist copayment**	**$15**	■ **Specialist copayment**	**$15**	■ **Specialist copayment**	**$15**
■ **Hospital (facility) coinsurance**	**10%**	■ **Hospital (facility) coinsurance**	**10%**	■ **Hospital (facility) coinsurance**	**10%**
■ **Other coinsurance**	**10%**	■ **Other coinsurance**	**10%**	■ **Other coinsurance**	**10%**
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	$1,600	Deductibles	$1,600	Deductibles	$1,600
Copayments	$0	Copayments	$713	Copayments	$45
Coinsurance	$1,000	Coinsurance	$286	Coinsurance	$52
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	**$2,661**	**The total Joe would pay is**	**$2,621**	**The total Mia would pay is**	**$1,697**

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.

ملحوظة: إذا كنت تتحدث اللغة العربية\الكردية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل بالرقم (800) 422-4641 أو خدمة الهاتف النصي: 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.

Administered by Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company (Alliance)
Self-Funded Preferred Provider Organization (PPO)
Summary of Benefits

AS000119 / XR003082 **Self-Funded PPO**

AAS000119 / XR003082

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,600 Self Only; $3,200 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$2,600 Self Only; $5,200 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	Deductible does not include copays or coinsurance. In and Out-of-Network deductibles accumulate separately. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	10%	30%	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$2,600 Self Only; $5,200 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$3,600 Self Only; $7,200 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	These values do not accumulate: premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified. In and Out-of-Network Out-of-Pocket Maximums accumulate separately.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	Not Covered	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	Not Covered	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	Not Covered	
Immunizations	Covered - Deductible does not apply	Not Covered	
Outpatient & Physician Services			
Primary Care Office Visit	$25 Copay after deductible	30% Coinsurance after deductible	
Telehealth Visit	$25 Copay after deductible	Not Covered	Through our contracted telehealth services provider.
Specialist Office Visit	$25 Copay after deductible	30% Coinsurance after deductible	
Routine Audiology Exam	Covered - Deductible does not apply	Not Covered	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	Not Covered	One exam per Benefit Period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	$25 Copay after deductible	30% Coinsurance after deductible	Manipulation of the spine for subluxation only. Up to 38 visits per benefit period (Combined In and Out-of-Network).
Allergy Treatment	10% Coinsurance after deductible	30% Coinsurance after deductible	
Allergy Injections	10% Coinsurance after deductible	30% Coinsurance after deductible	
Laboratory & Pathology	10% Coinsurance after deductible	30% Coinsurance after deductible	Some services require preauthorization.
Imaging MRI, CT & PET Scans	10% Coinsurance after deductible	30% Coinsurance after deductible	Services require preauthorization.
Radiology (X-ray)	10% Coinsurance after deductible	30% Coinsurance after deductible	Some services require preauthorization.
Radiation Therapy & Chemotherapy	10% Coinsurance after deductible	30% Coinsurance after deductible	
Dialysis	10% Coinsurance after deductible	30% Coinsurance after deductible	Out-of-Network benefits are not covered unless Prior Authorized.
Outpatient Medical Drugs	10% Coinsurance after deductible	30% Coinsurance after deductible	
Outpatient Surgical Services			
Outpatient Surgery	10% Coinsurance after deductible	30% Coinsurance after deductible	
Ambulatory Surgical Center	10% Coinsurance after deductible	30% Coinsurance after deductible	
Professional Surgical and Related Services	10% Coinsurance after deductible	30% Coinsurance after deductible	
Emergency/Urgent Care			
Urgent Care	10% Coinsurance after In-Network Deductible		
Emergency Room Care	10% Coinsurance after In-Network Deductible		
Emergency Medical Transportation	10% Coinsurance after In-Network Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	10% Coinsurance after deductible	30% Coinsurance after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	10% Coinsurance after deductible	30% Coinsurance after deductible	
Bariatric Surgery and Related Services	Not Covered	Not Covered	

Maternity Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	Not Covered	Covered under Preventive Services
Routine Postnatal Office Visits	Covered - Deductible does not apply	Not Covered	Covered under Preventive Services
Labor Delivery and Newborn Care	See Inpatient Hospital Services	See Inpatient Hospital Services	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	See Inpatient Hospital Services	
Outpatient Services	$25 Copay after deductible	30% Coinsurance after deductible	
Other Services			
Home Health Care	10% Coinsurance after deductible	30% Coinsurance after deductible	Does not include Rehabilitation Services. Up to 100 visits per benefit period (Combined In and Out-of-Network).
Hospice Care	10% Coinsurance after deductible	30% Coinsurance after deductible	Up to 210 days per lifetime (Combined In and Out-of-Network).
Skilled Nursing Care	10% Coinsurance after deductible	30% Coinsurance after deductible	Up to 100 days per benefit period (Combined In and Out-of-Network).
Durable Medical Equipment; Prosthetics & Orthotics	10% Coinsurance after deductible	30% Coinsurance after deductible	Covered for approved equipment only.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$25 Copay after deductible	30% Coinsurance after deductible	May be rendered at home. Up to 60 combined visits per benefit period (Combined In-Network and Out-of-Network).
Habilitation Services: Physical, Occupational, and Speech Therapy	$25 Copay after deductible	Not Covered	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	$25 Copay after deductible	Not Covered	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	See Outpatient Surgical Services	Limited to vasectomy
Voluntary Termination of Pregnancy	See Outpatient Surgical Services	See Outpatient Surgical Services	During first trimester only. Limited to 1 within a 24 month period.
Infertility Services	10% Coinsurance after deductible	30% Coinsurance after deductible	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	10% Coinsurance after deductible	30% Coinsurance after deductible	One attempt per lifetime.
Temporomandibular Joint Disorder	Not Covered	Not Covered	
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply after deductible		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Non-Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply after deductible		
Preferred Brand Drugs	$50 Copay 30 day supply, $100 Copay 90 day supply after deductible		
Non-Preferred Brand Drugs	$50 Copay 30 day supply, $100 Copay 90 day supply after deductible		
Preferred Specialty Drugs	$50 Copay 30 day supply at specialty pharmacy only after deductible		
Non-Preferred Specialty Drugs	$50 Copay 30 day supply at specialty pharmacy only after deductible		
Infertility Drugs	50% Coinsurance 30 day supply only after deductible		

- In case of conflict between this summary and your Self-Funded PPO Benefit Guide, the terms and conditions of the Self-Funded PPO Benefit Guide will govern.
- This self-funded plan includes a network of health care providers through which services are covered at the In-Network level of benefits. If you receive covered services from a provider that is not part of the plan's network, benefits will be provided at the lower Out-of-Network benefit level.
- Elective hospital admissions require that Alliance be notified prior to the admission. Alliance must be notified within 48 hours after an emergency hospital admission. Failure to notify Alliance could result in a reduction or denial of benefits.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.
- Self-Funded PPO plans are administered by Alliance Health and Life Insurance Company, a wholly owned subsidiary of Health Alliance Plan.
-For Outpatient Mental Health & Substance Use Disorder Services delivered via Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the Telehealth Cost-Share.

Alliance Health and Life Insurance Company AS000119 / XR003082

Coverage for: Individual + Family | Plan Type: ASO PPO QHDHP
AAS000119 XR003082

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 1-888-999-4347 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 1-888-999-4347 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**IN-NETWORK** **$1,600** self only coverage / **$3,200** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. **OUT-OF-NETWORK** **$2,600** self only coverage / **$5,200** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. some Office Visits, Preventive services, some 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.

Important Questions	Answers	Why This Matters:
What is the out-of-pocket limit for this plan?	**IN-NETWORK:** **Out-of-Pocket Limit:** **$2,600** self only coverage / **$5,200** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. **OUT-OF-NETWORK:** **Out-of-Pocket Limit:** **$3,600** self only coverage / **$7,200** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	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, the overall family out-of-pocket limit must be 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 1-888-999-4347 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?	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	$25 Copay after deductible	30% Coinsurance after deductible	
	Specialist visit	$25 Copay after deductible	30% Coinsurance after deductible	
	Other practitioner office visit	Telehealth Visit: $25 Copay after deductible Chiropractic Visit: $25 Copay after deductible	30% Coinsurance after deductible	Telehealth: Through our contracted telehealth services provider. Not covered Out-of-Network. Chiropractic: Manipulation of the spine for subluxation only. Up to 38 visits per benefit period (Combined In-Network and Out-of-Network).
	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)	10% Coinsurance after deductible	30% Coinsurance after deductible	Some services require preauthorization
	Imaging (CT/PET scans, MRIs)	10% Coinsurance after deductible	30% 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	Preferred Generic drugs	$10 Copay / prescription (retail) after deductible	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. Infertility Drug: 50% Coinsurance
	Non-preferred Generic drugs	$10 Copay / prescription (retail) after deductible	Not Covered	
	Preferred Brand drugs	$50 Copay / prescription (retail) after deductible	Not Covered	
	Non-preferred Brand drugs	$50 Copay / prescription (retail) after deductible	Not Covered	
	Preferred Specialty drugs	$50 Copay / prescription (retail) after deductible	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.
	Non-preferred Specialty drugs	$50 Copay / prescription (retail) after deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center(ASC))	10% Coinsurance after deductible	30% Coinsurance after deductible	Some services require preauthorization.
	Physician/surgeon fees	10% Coinsurance after deductible	30% Coinsurance after deductible	

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 immediate medical attention	Emergency room care	10% Coinsurance after In-Network deductible	10% Coinsurance after In-Network deductible	
	Emergency medical transportation	10% Coinsurance after In-Network deductible	10% Coinsurance after In-Network deductible	Emergency transport only
	Urgent care	10% Coinsurance after In-Network deductible	10% Coinsurance after In-Network deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance after deductible	30% Coinsurance after deductible	Some services require preauthorization.
	Physician/surgeon fees	10% Coinsurance after deductible	30% Coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay after deductible	30% Coinsurance after deductible	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755. OON Benefits do not apply to ABA.
	Inpatient services	10% Coinsurance after deductible	30% Coinsurance after deductible	Services require preauthorization. Services can be accessed by calling 1-800-444-5755.
If you are pregnant	Office visits	No Charge; deductible does not apply	Not Covered	Routine Prenatal and Routine Postnatal covered under Preventive Services.
	Childbirth/delivery professional services	10% Coinsurance after deductible	30% Coinsurance after deductible	
	Childbirth/delivery facility services	10% Coinsurance after deductible	30% Coinsurance after deductible	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	10% Coinsurance after deductible	30% Coinsurance after deductible	Does not include Rehabilitation Services. Up to 100 visits per benefit period (Combined In-Network and Out-of-Network).
	Rehabilitation services	$25 Copay after deductible	30% Coinsurance after deductible	May be rendered at home. Up to 60 combined visits per benefit period (Combined In-Network and Out-of-Network).
	Habilitation services	$25 Copay 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	10% Coinsurance after deductible	30% Coinsurance after deductible	Up to 100 days per benefit period (Combined In-Network and Out-of-Network).
	Durable medical equipment	10% Coinsurance after deductible	30% Coinsurance after deductible	Covered for approved equipment only
	Hospice services	10% Coinsurance after deductible	30% Coinsurance after deductible	Up to 210 days per lifetime (Combined In-Network and Out-of-Network).
If your child needs dental or eye care	Children's eye exam	$25 Copay after deductible	30% Coinsurance after deductible	One exam per benefit period. For non-routine visits see Specialist Office Visit.
	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
- Bariatric Surgery
- 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

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

- Chiropractic Care
- Infertility Treatment
- Routine Eye Care (Adult)
- Voluntary Termination of Pregnancy
- 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 1-888-999-4347 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 1-888-999-4347; 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**	**$1,600**	■ **The plan's overall deductible**	**$1,600**	■ **The plan's overall deductible**	**$1,600**
■ **Specialist copayment**	**$25**	■ **Specialist copayment**	**$25**	■ **Specialist copayment**	**$25**
■ **Hospital (facility) coinsurance**	**10%**	■ **Hospital (facility) coinsurance**	**10%**	■ **Hospital (facility) coinsurance**	**10%**
■ **Other coinsurance**	**10%**	■ **Other coinsurance**	**10%**	■ **Other coinsurance**	**10%**
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	$1,600	Deductibles	$1,600	Deductibles	$1,600
Copayments	$0	Copayments	$776	Copayments	$175
Coinsurance	$1,000	Coinsurance	$61	Coinsurance	$15
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	**$2,661**	**The total Joe would pay is**	**$2,459**	**The total Mia would pay is**	**$1,790**

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.

ملحوظة: إذا كنت تتحدث اللغة العربية\الكردية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل بالرقم (800) 422-4641 أو خدمة الهاتف النصي: 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.

Preventive Services Guide for Members Other Than Medicare Members

What are preventive services: Preventive services are tests or procedures provided to keep you healthy by looking for health issues or risks in people who don't have any diagnosis, history, or other known risk factors. It's meant to help prevent illness or find problems before any symptoms arise. The Benefit Administration Manual policy for Preventive Services gives more information such as ages, frequency as well as specific codes. Your doctor has access to tools that list the specific codes identified by HAP as preventive services.

What aren't preventive services: Services obtained to evaluate a complaint or symptom; in greater frequency or at different ages than recommended for screening; obtained out of network; or billed with service codes not designated as preventive. Tests used for these purposes are called diagnostic tests.

Product type and Recommendations: Coverage of preventive services for employer and individual products are based on United States Preventive Task Force Recommendations and Affordable Care Act recommendations. Medicare/Senior Plus based products are based on Medicare preventive services and are not addressed by this document. Medicaid/HAP Empowered products are based on USPSTF and ACA recommendations. Some products may not have coverage for "preventive services", please see Member's subscriber documents.

What's a well visit: A well visit is an evaluation scheduled at recommended intervals to check on your health status and point out concerns or risks that might prompt further investigation to maintain optimal health. A well visit is also known as a check-up. Visits to address a complaint such as a stomachache or an earache aren't considered well visits.

NOTE: The below charts reflect very basic information, not every test or service is listed. This document is intended as a guide and doesn't guarantee services. Please see the Benefit Administration Manual policy for the most current coverage information.

Infants, Children and Teens	**Member eligibility**	**Frequency** as a preventive service. Additional tests are covered as other medically necessary services.
Well child visits including but not limited to height, weight, growth & development.	All ages	Frequency follows American Academy of Pediatric recommendations based on child's age.
Healthy living:		
Autism screening	All ages	Annual. Intended as a component of a Well Child visit.
Behavioral screening	All ages	Annual. Intended as a component of a Well Child visit.
Depression, Anxiety & Suicide Risk screening	All ages	Annual. Intended as a component of a Well Child visit.
Developmental screening	All ages	Annual. Intended as a component of a Well Child visit.
Hearing & Vision screening	All ages	Annual. Intended as a component of a Well Child visit.

Obesity counseling & screening	All ages	Annual. Intended as a component of a Well Child visit.
Prevention of dental caries	All ages	Annual. Intended as a component of a Well Child visit.
Pregnancy counseling	Teens	Annual. Intended as a component of a Well Child visit.
Cervical cancer counseling,	Teens	Annual. Intended as a component of a Well Child visit.
HIV counseling & screening	Teens	Annual. Intended as a component of a Well Child visit.
Sexually transmitted infections counseling & screening	Teens	Twice per year
• Alcohol counseling & screening • Tobacco counseling & screening • Substance use counseling & screening	Teens	Annual. Intended as a component of a Well Child visit.
Immunizations: • Includes the Seasonal Flu shot, and all vaccines recommended for Children, including approved COVID vaccines and RSV prevention	Age-appropriate	Frequency as recommended by the American Academy of Pediatrics.
Preventive medications: • Iron supplements for infants at risk for anemia • Topical gonorrhea prophylactic medication • Fluoride varnish • HIV preexposure prophylaxis	• Infants • Newborns • Children under 5yrs old • Teens	• As indicated for the individual child • Once (billed as part of hospital stay) • Frequency as recommended by the American Academy of Pediatrics • Must meet criteria, covered as indicated.
Tests:		
• Newborn screening, • Sickle cell screening, • Bilirubin screening, • PKU screening • Thyroid screening	Infants	Once, each
• Anemia screening	All ages	Annual
• Cholesterol screening	All ages	Annual
• Lead screening	All ages	Annual
• TB skin testing	Age-appropriate	Annual
• Hepatitis B & C screening	Age-appropriate	Annual
• Refractive vision and hearing evaluations	Age-appropriate	Annual

Pregnancy *(In addition to all age-appropriate non-prenatal care)*	**Member eligibility**	**Frequency** as a preventive service.
Well Prenatal and Postnatal visits [also known as **routine visits**] including but not limited to weight and blood pressure monitoring, fetal heartbeat and fundal height monitoring.	All ages.	Frequency based on the American College of Obstetrician/Gynecologist recommendations.
Healthy living:		
• Alcohol counseling & screening • Substance use counseling & screening	All pregnant Members	Intended as a component of a Well prenatal visit.
• Tobacco counseling & screening • Tobacco cessation behavioral interventions	All pregnant Members	Intended as a component of a Well prenatal visit.
Anxiety screening	All pregnant Members	Intended as a component of a Well prenatal visit.
Depression & Suicide Risk screening	All pregnant Members	Frequency based on the American College of Obstetrician/Gynecologist recommendations. Intended as a component of a Well prenatal visit.
Healthy weight assessment & counseling	All pregnant Members	Intended as a component of a Well prenatal visit.
Hypertension & Pre-Eclampsia counseling & screening	All pregnant Members	Intended as a component of a Well prenatal visit.
Intimate partner violence,	All pregnant Members	Intended as a component of a Well prenatal visit.
Immunizations:	All pregnant Members	All recommended immunizations
Preventive medications: • Aspirin, Preeclampsia prevention • HIV preexposure prophylaxis	For Members at high risk	• After the first 12 weeks of pregnancy. • Must meet criteria, covered as indicated.
Breastfeeding supports: • Lactation instruction and support • Breast pump equipment & supplies	All pregnant or lactating Members	• Pre and postnatal • One breast pump per pregnancy
Tests		
Diabetes screening	All pregnant Members	Twice during pregnancy
Hepatitis B & C, HIV, & Sexually transmitted infections screening	All pregnant Members	Once during pregnancy
Asymptomatic Bacteriuria screening	All pregnant Members	Once per pregnancy
Rh assessment	All pregnant Members	Once each pregnancy (twice if Rh negative)
Fetal ultrasound	All pregnant Members	One per fetus

Adult Members	Member eligibility	**Frequency** as a preventive service. Additional tests are covered as other medically necessary services.
Well visits including but not limited to height, weight, heart rate, blood pressure	All ages	Annual
Healthy living:		
Advance care planning	All ages	Annual. Intended as a component of a Well visit.
Alcohol, Tobacco, and substance use counseling & screening	All ages	Annual. Intended as a component of a Well visit.
Anxiety screening	All ages	Intended as a component of a Well visit.
Cancer risk assessment • BRCA assessment & counseling • Cervical cancer screening • Colorectal cancer screening • Lung cancer counseling & screening • Prostate cancer screening • Skin cancer prevention counseling	All ages	Annual. Intended as a component of a Well visit.
Breast Cancer Genetic counseling	All ages	Once. Members at increased risk
Contraception including sterilization by tubal ligation.	All ages	Counseling and education intended as a component of a well visit.
Depression & Suicide Risk screening	All ages	Annual. Intended as a component of a Well visit.
Fall risk assessment/prevention	All ages	Annual. Intended as a component of a Well visit.
Hearing & Vision screening	All ages	Annual. Intended as a component of a Well visit.
HIV preexposure prophylaxis	For Members at high risk	As recommended by the CDC.
High blood pressure, hypertension counseling & screening	All ages	Annual. Intended as a component of a Well visit.
Intimate partner violence screening	All ages	Annual. Intended as a component of a Well visit.
Obesity, healthy diet and healthy lifestyle counseling & screening	All ages	Frequency based on service. Intended as a component of a Well visit.
Prediabetes & Type 2 Diabetes counseling & screening	All ages	Annual. Intended as a component of a Well visit.

Sexually transmitted infections counseling	All ages	Twice per year.
Tobacco smoking cessation – counseling & behavioral interventions	All ages	Eight visits/year. Intended as a component of a Well visit.
Urinary Incontinence counseling & screening:	All ages	Annual. Intended as a component of a Well visit.
Healthy weight assessment and counseling	All ages	Annual. Intended as a component of a Well visit.
Immunizations & Booster shots (*including but not limited to the following*) • Flu shot (seasonal) • Hepatitis A, B, HIV, meningococcal • Pneumococcal • Shingles • Tetanus • All other routine recommended vaccines, including approved COVID vaccines and RSV vaccines	• All Members • If high risk • If high risk or over age 65 • If high risk or over age 60 • All ages • Age-appropriate	• Seasonal • As recommended by the CDC • As recommended by the CDC • As recommended by the CDC • Every 10 years • As recommended by the CDC
Preventive medications: • BRCA medication for prevention • Folic acid • HIV preexposure prophylaxis • Statins	• All ages • All ages • All ages • 40-75 yrs	• Member must meet criteria • Member of childbearing age • Member must meet criteria • As directed.
Contraceptives: • All Food & Drug Administration approved contraceptive methods including emergency contraceptives, tubal ligation procedures, and related counseling and education.	Female Members	As prescribed by provider for preventive purposes, consistent with ACA & HRSA guidelines and subject to subscriber contracts.
Tests:		
Cholesterol testing	All Adult Members	Annual
Diabetes screening, (Hemoglobin A1C)	All Adult Members	Annual
Hepatitis B & C, HIV, & STD screening	All Adult Members	Frequency based on testing
Lead screening	All Adult Members	Annual
TB skin testing/ TB screening	All Adult Members	Annual
BRCA genetic testing	All Adult Members	Once. Must meet criteria.
Screening procedures & tests:		
Abdominal aortic aneurysm screening	Male Members age 65- 75 with history of smoking	Once per lifetime

Breast cancer screening (mammograms)	Female Members over age 40 years and those at increased risk	Screening mammogram: every one to two years
Cervical cancer screening (pap smears)	All Adult Members	Frequency based on type of testing
Colorectal cancer screening	All Adult Members	Frequency based on type of testing
Diabetic retinopathy screening	All Adult Members with Diabetes	Annual
Glaucoma screening	All Adult Members	Annual
Lung Cancer screening	Age 50-80 meeting criteria	Annual
Osteoporosis screening (Bone density testing)	Adult members meeting criteria	Every two years
Prostate cancer screening	All Adult Members	Annual
Refractive Vision and hearing evaluation	All Adult Members	Annual
Sexually transmitted infections screening (including Chlamydia & Gonorrhea, syphilis)	All Adult Members	Annual

Please note: Coverage as a preventive service with no Member cost share is based on the use of billing codes listed as specific preventive services and network limitations as described in the Related Benefit Administration Manual policies:

- **Preventive Services for Members Other Than Medicare Members**
- **Preventive Service: Mammography**
- **Preventive Services - Colorectal Cancer Screening for Members OTHER THAN Medicare Advantage Members**
- **Routine Prenatal and Postnatal Care**

Medicare plan Members are not addressed by this document. Please refer to the Benefit Administration Manual policies:

- **Preventive Services for Medicare Advantage Members**
- **Preventive Service: Mammography**
- **Preventive Services - Colorectal Cancer Screening for Medicare Advantage Members**

HAP and its subsidiaries do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

 HAP278742 – 8/2023