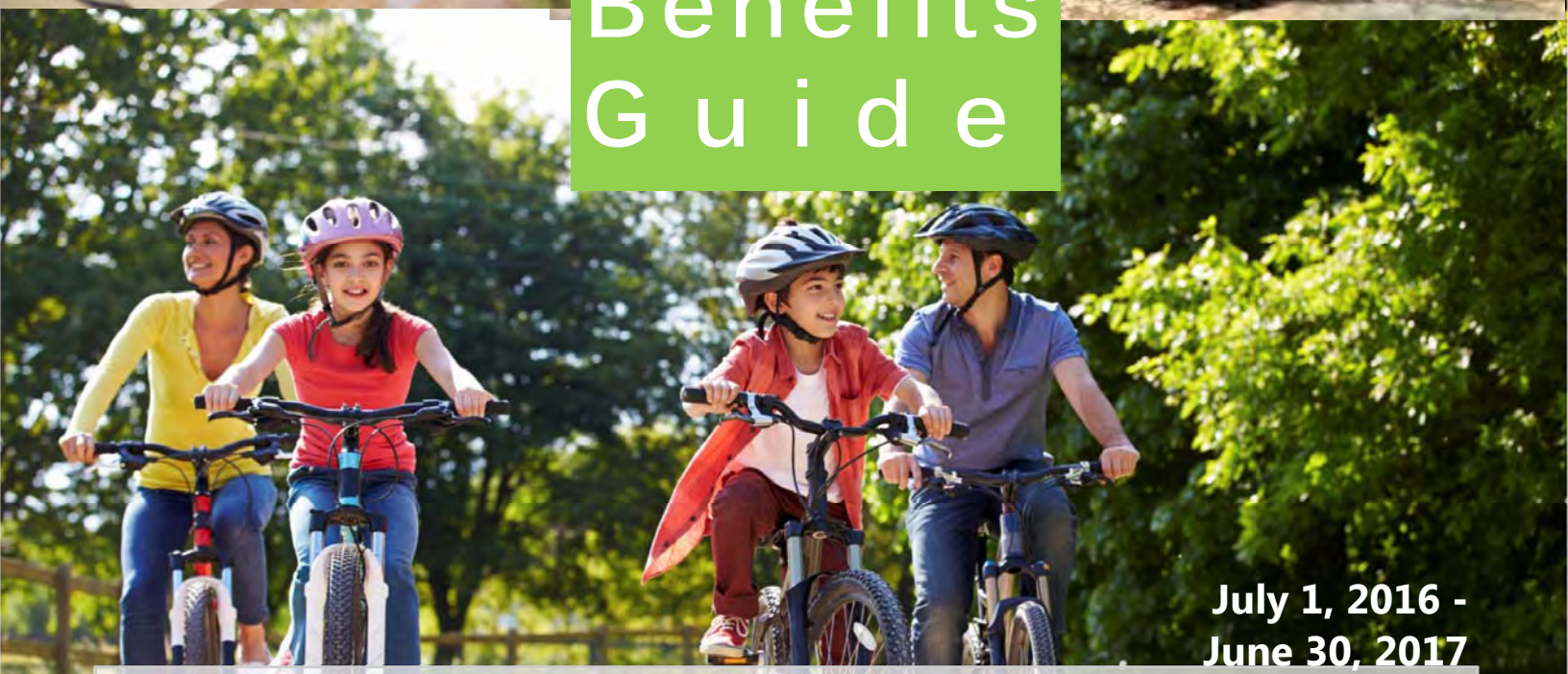
DSEHP
DEARBORN SCHOOLS EMPLOYEE HEALTHCARE PROGRAM
DFT - DEARBORN FEDERATION OF TEACHERS
DFSE - DEARBORN FEDERATION OF SCHOOL EMPLOYEES
ADSA - ASSOCIATION OF DEARBORN SCHOOL ADMINISTRATORS
DSOEA - DEARBORN SCHOOLS OPERATING ENGINEERS ASSOCIATION

AE

A Complete Benefits Package
for Your Complete Life

2016 Employee Benefits Guide



July 1, 2016 - June 30, 2017

Medicare Part D
Prescription Drug Information

If you have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage.
Please see page 7 for more details.

Open Enrollment Process

Open Enrollment for making insurance benefit changes will be from May 2nd through May 31st .

All employees will be required to enroll in coverage by making an election for benefits. Your current Medical elections will **not** be rolled over into the new plan year and you must make an election during the Open Enrollment period in order for your benefits to continue to be effective for the new plan year.

You have three different methods to enroll:

- Online
- Over the Phone
- Onsite Enrollment

Instructions for these three enrollment methods are on page 4 of this newsletter.

Remember that the choices you make now will be effective July 1, 2016 and will remain in effect until June 30, 2017 unless you experience a qualified special enrollment event.

If you do not make an election for benefits by May 31, 2016, your benefit coverage will be terminated effective June 30, 2016.

Overview of Benefit Changes

The following changes will be effective July 1, 2016.

Medical

- No Changes

Eligibility

- Employee's spouse by legal marriage if recognized under the laws of the employee's state of domicile, including any same sex marriages.
- Dependent children are eligible for coverage until the end of the month in which they turn 26.

Inside this Issue…..

Benefit Enrollment Instructions
Effective Monday, May 2, 2016

Online Enrollment System:

To access your benefits online, go to: www.nextgenerationenrollment.com/nge/login anytime.

Enter your username. Your username is the first initial of your first name, the first six characters of your last name, and the last four digits of your Social Security number. *For example, if your name is John Williams, and the last four digits of your Social Security number are 1234, your username will look like this: jwillia1234.*

Enter your password. Your password is your date of birth in a number format without any punctuation, starting with the year you were born, then the month and then the date (YYYYMMDD). *For example, if your date of birth is January 5, 1970, your password will look like this: 19700105.*

Once you have logged in, you will be prompted to change your password.

Over the Phone:

If you prefer to speak directly to a representative in the Benefit Center who will assist you in making your elections and with technical support, please call the Benefit Center at **(888) 222-4309**. Representatives are available between the hours of 8 a.m. and 11 p.m. EST, Monday through Friday.

When you call, the Benefit Center will ask you to verify the last four digits of your Social Security number and your date of birth. From that point, the representative will walk you through your personal information on file to confirm its accuracy. Please be prepared to first provide verbal authorization if you would like your spouse to speak with a representative on your behalf.

Onsite Enrollment:

If you prefer to enroll online yourself but would like personal assistance using the new system, please call **888-222-4309** to make an appointment. The office is located at:

15250 Mercantile Dr.
Dearborn, MI 48120

Please remember that Open Enrollment will end at midnight on May 31, 2016.

If you do not make an election for benefits by May 31, 2016, your benefit coverage will be terminated effective June 30, 2016.

Medical & RX

Below is an overview of the copays effective July 1st. A full benefit summary is available on page 5 and a detailed Summary of Benefits and Coverage is available starting on page 8.

Benefit	Service Type	No Changes
Medical	PHP/MHSA Visit	$20
	Specialist	$30
	Urgent Care	$40
	Emergency Room	$200
Prescription	Generic	$10
	Preferred	$30
	Non-Preferred	$50

Employee Contributions

As determined by the Collective Bargaining Agreement.

Medical & RX Summary

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits for
DSEHP-DEARBORN FEDERATION OF TEACHERS

AA000775 / XR000506

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:		
Benefit Period:	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Annual Out-of-Pocket Maximum	$6,600 Individual ; $13,200 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover. All other cost-sharing accumulates.
Preventive Services:		
Preventive Office Visit / Physical Exam	Covered	
Well Baby Office Visit	Covered	
Routine Hearing Exam	Covered	
Routine Eye Exam	Covered	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	$20 Copay	
Specialty Physician Office Visit	$30 Copay	
Gynecology Office Visit	$30 Copay	
Audiology Office Visit	$30 Copay	
Eye Exam Office Visit	$30 Copay	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	Covered	
Chiropractic Office Visit and Related Services	$30 Copay	Up to 35 visits per benefit period
Emergency/Urgent Care:		
Emergency Room Services	$200 Copay	Copay will be waived if admitted
Urgent Care Facility Services	$40 Copay	
Emergency Ambulance Services	Covered	Emergency transport only
Inpatient Hospital Services:		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary. Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	
Bariatric Surgery & Related Services	$1,000 Copay	One procedure per lifetime
Maternity Services:		
Initial Prenatal Office Visit	Covered	Covered under Preventive Services
Subsequent Prenatal Office Visits	Covered	Covered under Preventive Services
Postnatal Office Visits	$30 Copay	
Labor, Delivery and Newborn Care	Covered	
Mental /Behavioral Health:		
Inpatient Services	Covered	
Outpatient Services	$20 Copay	
Substance Use Disorder:		
Inpatient Services	Covered	
Outpatient Services	$20 Copay	
Other Services:		
Home Health Care	Covered	Unlimited
Hospice Care	Covered	Up to 210 days per lifetime
Skilled Nursing Care	Covered	Covered for authorized services - Up to 100 days per benefit period
Durable Medical Equipment; Prosthetic & Orthotics	Covered	Coverage provided for approved equipment based on HAP's guidelines
Hearing Aid Hardware	Covered	Covered for authorized equipment
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Covered	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Plan Pays 100%	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. **Women: Covered as Preventive Service**
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Plan Pays 50%	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Not Covered	
Pharmacy:		
Generic / Preferred Brand / Non-Preferred Brand	$10 / $30 / $50 Copay	Retail: 30 day supply for non-maintenance drugs at 1 Copay; 90 day supply for eligible maintenance drugs at 2 Copays Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays

Rev 08/2012

Benefit Riders: K60,MHE,012,013,073,124,203,272,313,317,599,J05,449

* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.
* Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.
* In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.
* Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.

Your Rights Under Federal Law

Change in Status or Special Enrollment -

You may qualify for a special enrollment if certain events occur in your life:

- If you decline coverage for yourself and/or your dependents (including your spouse) because you are covered under another health plan, you may be able to enroll yourself and/or your dependents in the plan if you experience an involuntary loss of that coverage (e.g., spouse loses his/her job, divorce).
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the plan.

In either situation, you must request enrollment through the DSEHP Benefit Center within 30 days after the special enrollment event as described above. If you enroll as the result of a special enrollment event, coverage will be made effective on the date of the event.

Newborn and Mother's Health Protection Act -

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health Cancer Rights Act Notice -

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis;
- Physical complication during all stages of mastectomy, including lymph edemas.

The plan may not:

- Interfere with a woman's right under the plan to avoid these requirements;
- Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and co-insurance requirements consistent with other coverage provided under the plan.

Patient Protection Notice -

HAP generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in HAP's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of participating primary care providers, contact HAP at 877-427-3678. For children you may designate a pediatrician as the primary care provider.

You do not need prior authorization from HAP or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact HAP at 877-427-3678.

Important Notice from Dearborn Schools Employee Healthcare Program (DSEHP) About Your CREDITABLE Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with DSEHP and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **DSEHP has determined that the prescription drug coverage offered by the HAP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected.

Summary of Options for Medicare Eligible Employees (and/or Dependents):

- Continue medical and prescription drug coverage and do not elect Medicare D coverage. **Impact** – your claims continue to be paid by DSEHP health plan.
- Continue medical and prescription drug coverage and elect Medicare D coverage. **Impact** - As an active employee (or dependent of an active employee) the DSEHP health plan continues to pay primary on your claims (pays before Medicare D).
- Drop the coverage and elect Medicare Part D coverage. **Impact** – Medicare is your primary coverage. You will not be able to rejoin the DSEHP health plan unless you experience a family circumstance change or until the next open enrollment period.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back unless you experience a family status change or until the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with HAP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information [or call Office Manager, NGE at [(313) 9823292]. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through DSEHP changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

Visit www.medicare.gov
Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: July 1, 2016
Name of Entity/Sender: DSEHP
Contact--Position/Office: Office Manager, NGE
Address: 15250 Mercantile Dr., Dearborn MI 48120
Phone Number: 888-222-4309

CMS Form 10182-CC
Updated April 1, 2011
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 2 1244-1850

General Notice Of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: DSEHP Benefit Center, 15250 Mercantile Drive, Dearborn MI 48120 or call 888-222-4309

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please call the DSEHP benefit center at 888-222-4309 if this occurs.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

DSEHP Benefit Center
15250 Mercantile Drive
Dearborn, MI 48120
888-222-4309

Health Alliance Plan

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hap.org or by calling 1-800-422-4641.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$6,600** person / **$13,200** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, Balance Billed Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See **www.hap.org or call 1-800-422-4641** for a list of **preferred providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-422-4641 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not Covered	----------None----------
	Specialist visit	$30 copay per visit	Not Covered	----------None----------
	Other practitioner office visit	$20 PCP Other Practitioner copay per visit/ $30 Specialist Other Practitioner copay per visit	Not Covered	Chiropractic manipulation of the spine for subluxation only - 35 visits per benefit year Acupuncture Not Covered
	Preventive care/screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Some services require prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hap.org.	Generic Drugs	$10 copay/prescription (retail).	Not Covered	Applies to all categories below. Retail: 30 day supply for non-maintenance drugs at 1 copay; 90 day supply for eligible maintenance drugs at 2 copays; Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 copays
	Preferred brand drugs	$30 copay/prescription (retail).	Not Covered	
	Non-preferred brand drugs	$50 copay/prescription (retail).	Not Covered	
	Specialty drugs	$50 copay/prescription (retail).	Not Covered	

Questions: Call 1-800-422-4641 or visit us at www.hap.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800 422-4641 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fees	No Charge	Not Covered	----------None----------
If you need immediate medical attention	Emergency room services	$200 copay per visit	$200 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency Transport Only
	Urgent care	$40 copay per visit	$40 copay per visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require prior authorization.
	Physician/surgeon fee	No Charge	Not Covered	----------None----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Mental/Behavioral health inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder outpatient services	$20 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder inpatient services	No Charge	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
If you are pregnant	Prenatal and postnatal care	$30 copay per visit	Not Covered	No Charge for Prenatal care
	Delivery and all inpatient services	No Charge	Not Covered	Some services require prior authorization.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	Not Covered	----------None----------
	Rehabilitation services	No Charge after deductible	Not Covered	Up to 60 combined visits per benefit period - May be rendered at home
	Habilitation services	No Charge 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. Services require prior authorization. *See outpatient Mental Health for ABA cost share amount.
	Skilled nursing care	No Charge after deductible	Not Covered	Covered for authorized services - Up to 100 days per benefit period
	Durable medical equipment	No Charge after deductible	Not Covered	Coverage provided for approved equipment based on HAP's guidelines.
	Hospice service	No Charge after deductible	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Eye exam	$30 copay per visit	Not Covered	No Charge for preventive eye exam
	Glasses	Not Covered	Not Covered	----------None----------
	Dental check up	Not Covered	Not Covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care (Only when meets Plan guidelines)
- Vision Hardware (Unless additional rider purchased)

Questions: Call 1-800-422-4641 or visit us at www.hap.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-422-4641 to request a copy.

Excluded Services & Other Covered Services:

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

• Bariatric Surgery	• Hearing Aids	• Routine Eye Care (Adult)
• Chiropractic Care	• Infertility Treatment (Only when meets Plan guidelines)	• Weight Loss Programs

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact HAP at 1-800-422-4641or visit us at www.hap.org

For more information regarding grievance and appeals, 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Office 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $7,340**
- **Patient pays $200**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$50
Co-insurance	$0
Limits or exclusions	$150
Total	**$200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $4,620**
- **Patient pays $780**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$80
Total	**$780**

Health Alliance Plan

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | **Plan Type:** HMO

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Your Benefit Resources

Medical & Prescription Drug	**HAP**	**877-427-3678** **www.hap.org**

Other Questions or Changes In Eligibility

Arthur J. Gallagher & Co.

888-222-4309

The contents of this booklet is intended for use as an easy to read summary only. It does not constitute a contract. Additional limitations and exclusions may apply. For an official description of benefits, please refer to each carrier's official certificate/benefit guide.