The following pages list the

Summary of Benefit's Coverage for

324 A & B

Active & Retiree

BCBS Individual & 2 Person/Family

and

HAP Individual & 2 Person/Family

Effective January 1, 2017

Retirees	Retiree Monthly	Retiree Monthly		Active Bi-Weekly	Active Bi-Weekly
Monthly Coverage	BCBS	HAP		BCBS	HAP
Single Not Med Elig	57.30	66.58		28.65	33.29
Single Med Elig	0	0		N/A	N/A
2 Pers Not Med Elig	137.54	153.16		68.77	76.58
2 Pers 1 Med Elig	57.30	66.58		N/A	N/A
2 Pers 2 Med Elig	0	0		N/A	N/A
Fam Not Med Elig	171.18	166.46		85.59	83.23
Fam 1 Med Elig	137.54	153.16		N/A	N/A
Fam 2 Med Elig	57.30	66.58		N/A	N/A
Fam Med Elig	0	0		N/A	N/A

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 BCBSM.COM or by calling the number on the back of your BCBSM ID card.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** member/**$1,000** family in-network / **$1,000** member/**$2,000** family out-of-network	You must pay all the costs up to the **deductible** amount before this plan begins to pay coverage services you use. See the chart starting on page 2 for how much you pay for covered services after deductible. Note: Out of network **deductible** amounts also apply toward the in network deductible.
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 this plan covers.
What is the co-insurance maximum?	Yes. **$500** member/$**1,000** family in-network / **$1,000** member/**$2,000** family out-of-network	The co-insurance maximum is the most you could pay during a coverage period (usually one year) for your 10% share of the cost of covered services after the deductible is met. This limit helps you plan for health care expenses.
Is there an out-of-pocket limit on my expenses?	Yes. **$1,000** member/$**2,000** family in-network / **$2,000** member/**$4,000** family out-of-network	The out of-pocket limit is the most you could pay during a coverage period (usually on year) for your share of the cost of covered services. This limit **includes** deductible amounts. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, copayments, cost shares and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out of pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.bcbsm.com or call the number on the back of your BCBSM ID card.	If you use an in-network doctor or provider, this plan will pay more of the claim than out-of-network providers for covered services; see the chart starting on page 2. Be aware, an in-network doctor or hospital may use an out-of-network provider for some services; ask before services are performed to see which charges would apply.

Questions: Call the number on the back of your BCBSM ID card or visit at www.bcbsm.com. 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/healthreform or call Human Resources - Employee Benefits at 734-247-3236 to request a copy.

Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 **in network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** 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 co-pay/visit	20% coinsurance after deductible	----------none----------
	Specialist visit	$20 co-pay/visit	20% coinsurance after deductible	----------none----------
	Other practitioner office visit	$20 co-pay/visit for chiropractic and osteopathic manipulative therapy	20% coinsurance after deductible	Limited to a combined maximum of 24 visits per member per calendar year
	Preventive care/screening/immunization	No Co-pay	Not applicable	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	20% coinsurance after deductible	----------none----------

Questions: Call the number on the back of your BCBSM ID card or visit at www.bcbsm.com. 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/healthreform or call Human Resources - Employee Benefits at 734-247-3236 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
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	20% coinsurance after deductible	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com	Generic drugs	$5 copayment	$5 copay + 25% coinsurance	Some medications may have quantity limits A list of these drugs is available at www.bcbsm.com. Mandatory preauthorization requires a physician obtain prior approval before covering select prescription drugs including 'Step Therapy' which applies criteria to select drugs to determine if a less costly drug may be used. *If you request a brand name drug when a generic drug is available, **without prior authorization,** you may be responsible for the difference between the maximum allowable cost and the approved amount for the named drug, in addition to your copayment.
	Preferred brand drugs	$30 copayment*	$30 copay + 25% coinsurance	
	Non-preferred brand drugs	$50 copayment*	$50 copay + 25% coinsurance	
	Specialty drugs	$50 copayment*	$50 copay + 25% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	20% coinsurance after deductible	----------none----------
	Physician/surgeon fees	10% coinsurance after deductible	20% coinsurance after deductible	----------none----------
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	Copayment waived if admitted or for accidental injury.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	----------none----------
	Urgent care	$20 co-pay/visit	20% coinsurance after deductible	----------none----------

Questions: Call the number on the back of your BCBSM ID card or visit at www.bcbsm.com. 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/healthreform or call Human Resources - Employee Benefits at 734-247-3236 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 a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	20% coinsurance after deductible	----------none----------
	Physician/surgeon fee	10% coinsurance after deductible	20% coinsurance after deductible	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance after deductible	20% coinsurance after deductible	Your cost share may be different for services performed in an office setting.
	Mental/Behavioral health inpatient services	10% coinsurance after deductible	20% coinsurance after deductible	----------none----------
	Substance use disorder outpatient services	10% coinsurance after deductible	20% coinsurance after deductible	----------none----------
	Substance use disorder inpatient services	10% coinsurance after deductible	20% coinsurance after deductible	----------none----------
If you are pregnant	Prenatal and postnatal care	Covered	20% coinsurance after deductible	----------none----------
	Delivery and all inpatient services	10% coinsurance after deductible	20% coinsurance after deductible	----------none----------
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	10% coinsurance after deductible	----------none----------
	Rehabilitation services – physical, occupational, and speech	10% coinsurance after deductible	10% coinsurance after deductible	Includes 60 visits annually combined.
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	10% coinsurance after deductible	10% coinsurance after deductible	Participating skilled nursing facility– Max 120 days per member per year.
	Durable medical equipment	10% coinsurance after deductible	10% coinsurance after deductible	----------none----------
	Hospice service	Covered	Covered	----------none----------
If your child needs dental or eye care	Eye exam	See your CBA	See your CBA	Retirees submit itemized receipt & form to WCAA/Actives-Enrollment for NVA required

Questions: Call the number on the back of your BCBSM ID card or visit at www.bcbsm.com. 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/healthreform or call Human Resources - Employee Benefits at 734-247-3236 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
	Glasses	See your CBA	See Your CBA	Retirees submit itemized receipt & form to WCAA/Actives-Enrollment for NVA required
	Dental check-up	N/A	N/A	Coverage available under Golden or up to $1500 annually per member under BCBS(@ a Cost for Retirees)

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
- Weight Loss Programs
- Cosmetic Surgery

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
- Chiropractic care
- Private Duty Nursing

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 734-247-3236. 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 x 61565 or www.cciio.cms.gov.

Questions: Call the number on the back of your BCBSM ID card or visit at www.bcbsm.com. 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/healthreform or call Human Resources - Employee Benefits at 734-247-3236 to request a copy.

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: Heather Day, Director of Benefits & Compensation at 734-247-3236.

Language Access Services

For assistance in a language below, please call the number on the back of your BCBSM ID card.

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

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** $ 6,460
- **Patient pays** $ 1,080

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:

Deductible	$500
Co-pays (assumes 2 brand name prescriptions/2nd tier)	$60
Co-insurance (assumes 90%/10%)	$520
Limits or exclusions	$0
Total	**$1,080**

***It is assumed that services were performed at participating providers & deductible hadn't been met for a family. Note: Copay amounts do not count toward out-of-pocket maximums.**

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

- **Amount owed to providers:** $ 5,400
- **Plan pays** $ 4,280
- **Patient pays** $1,120

Sample care costs:

Prescriptions – 12 month's worth	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures – 12 visits	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Co-pays (assumes 12 Rx,12 office)	$480
Co-insurance	$140
Limits or exclusions	$0
Total	**$1,120**

***It is assumed that services were performed at participating providers and deductible hadn't been met for a single person. Note: Copay amounts do not count toward out-of-pocket maximums.**

Questions: Call the number on the back of your BCBSM ID card or visit at www.bcbsm.com. 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/healthreform or call Human Resources - Employee Benefits at 734-247-3236 to request a copy.

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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

Questions: Call the number on the back of your BCBSM ID card or visit at www.bcbsm.com. 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/healthreform or call Human Resources - Employee Benefits at 734-247-3236 to request a copy.

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 hap.org or by calling the number on the back of your HAP ID card.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** member in-network / **$1,000** family in-network	You must pay all the costs up to the **deductible** amount before this plan begins to pay coverage services you use. See the chart starting on page 2 for how much you pay for covered services after deductible.
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 this plan covers.
What is the co-insurance maximum?	Yes. **$500** member/ $**1,000** family in-network	The **co-insurance maximum** is the most you could pay during a coverage period (usually one year) for your 10% share of the cost of covered services after the deductible is met. This limit helps you plan for health care expenses.
Is there an out–of–pocket limit on my expenses?	Yes. **$1,000** member**/$2,000** family in network.	The **out of pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit **includes** deductible amounts. This helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, copayments, cost shares and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes.	For a list of preferred providers, see www.hap.org or by calling 1-800-801-1766.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call the number on your HAP ID card or visit 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/healthreform or call Human Resources – Employee Benefits at 734-247-3236 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 **in network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** 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 co-pay/visit	Not applicable	Deductible does not apply
	Specialist visit	$20 co-pay/visit	Not applicable	Deductible does not apply
	Other practitioner office visit	$20 co-pay/visit	Not applicable	Deductible does not apply
	Preventive care/screening/immunization	$20 co-pay/visit	Not applicable	Deductible does not apply
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	Not applicable	----------none----------
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	Not applicable	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hap.org	Generic drugs	$5 copay	Not applicable	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 and non-maintenance drugs at 2 copays.
	Preferred brand drugs	$30 copay	Not applicable	
	Non-preferred brand drugs	$50 copay	Not applicable	
	Specialty drugs	$50 copay	Not applicable	

Questions: Call the number on your HAP ID card or visit 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/healthreform or call Human Resources – Employee Benefits at 734-247-3236 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)	10% coinsurance after deductible	Not applicable	----------none----------
	Physician/surgeon fees	10% coinsurance after deductible	Not applicable	----------none----------
If you need immediate medical attention	Emergency room services	$100 co-pay/visit	Emergency Treatment Only	Waived if admitted or accidental injury. Treatment allowed for out-of-network for emergency treatment only.
	Emergency medical transportation	10% coinsurance after deductible	Not applicable	Must be medically necessary.
	Urgent care	$20 co-pay/visit	Not applicable	Must be medically necessary in out of network.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not applicable	----------none----------
	Physician/surgeon fee	10% coinsurance after deductible	Not applicable	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay/visit	Not applicable	----------none----------
	Mental/Behavioral health inpatient services	10% coinsurance after deductible	Not applicable	----------none----------
	Substance use disorder outpatient services	$20 co-pay/visit	Not applicable	----------none----------
	Substance use disorder inpatient services	10% coinsurance after deductible	Not applicable	----------none----------
If you are pregnant	Prenatal and postnatal care	$20 co-pay/visit	Not applicable	----------none----------
	Delivery and all inpatient services	10% coinsurance after deductible	Not applicable	----------none----------

Questions: Call the number on your HAP ID card or visit 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/healthreform or call Human Resources – Employee Benefits at 734-247-3236 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 need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	Not applicable	Must be by RN or LPN; See PT/OT/ST Coverage Below
	Rehabilitation services – physical, occupational, and speech	10% coinsurance after deductible	Not applicable	Includes 60 visits annually combined.
	Habilitation services	10% coinsurance after deductible	Not applicable	
	Skilled nursing care	10% coinsurance after deductible	Not applicable	Covered for authorized services- up to 730 Days Renewable after 60 days
	Durable medical equipment	10% coinsurance after deductible	Not applicable	Must be authorized equipment based on HAP's guidelines.
	Hospice service	10% coinsurance after deductible	Not applicable	Covered 210 days per lifetime
If your child needs dental or eye care	Eye exam	See your CBA	See your CBA	Retirees submit itemized receipt & form to WCAA/Actives-Enrollment for NVA required
	Glasses	See your CBA	See your CBA	Retirees submit itemized receipt & form to WCAA/Actives-Enrollment for NVA required
	Dental check-up	N/A	N/A	Coverage available under Golden or up to $1500 annually per member under BCBS (@ a Cost for Retirees)

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.)

- Experimental Treatments
- Chiropractic Office Visit and Related Services
- Weight Loss Programs
- Cosmetic Surgery

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 & Related Services
  (1 procedure per lifetime)

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 734-247-7235. 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 x 61565 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: Heather Day, Director of Benefits & Compensation at 734-247-3236.

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

Questions: Call the number on your HAP ID card or visit 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/healthreform or call Human Resources – Employee Benefits at 734-247-3236 to request a copy.

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** $6,480
- **Patient pays** $1060

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	$500
Co-pays (assumes 2 brand name prescriptions / 2nd tier)	$60
Co-insurance (assumes 90%/10%)	$520
Limits or exclusions	$0
Total	**$1060**

***It is assumed that services were performed at participating providers & deductible hadn't been met for family coverage. Note: Copay amounts do not count toward out-of-pocket maximums.**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,280
- **Patient pays** $1,120

Sample care costs:

Prescriptions – 12 months worth	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures – 12 visits	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Co-pays(assumes 12Rx, 12 office)	$480
Co-insurance	$140
Limits or exclusions	$0
Total	**$1,120**

***It is assumed that services were performed at participating providers & deductible hadn't been met for single coverage. Note: Copay amounts do not count toward out-of-pocket maximums.**

Questions: Call the number on your HAP ID card or visit 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/healthreform or call Human Resources – Employee Benefits at 734-247-3236 to request a copy.

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.

Questions: Call the number on your HAP ID card or visit 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/healthreform or call Human Resources – Employee Benefits at 734-247-3236 to request a copy.