Monthly Subscriber/Member Level Rate Grid

Rates Effective Period: February 01, 2024 Through January 31, 2025

AHL Plans

01 PPO Platinum A0		02 PPO Platinum A025		03 PPO Platinum A050		04 PPO Gold B1		05 PPO Gold B12	
Age Band	Monthly Premium	Age Band	Monthly Premium	Age Band	Monthly Premium	Age Band	Monthly Premium	Age Band	Monthly Premium
0 - 14	$398.18	0 - 14	$386.67	0 - 14	$377.09	0 - 14	$291.53	0 - 14	$304.90
15	$433.58	15	$421.04	15	$410.61	15	$317.44	15	$332.00
16	$447.11	16	$434.19	16	$423.43	16	$327.35	16	$342.36
17	$460.64	17	$447.33	17	$436.25	17	$337.26	17	$352.73
18	$475.22	18	$461.48	18	$450.05	18	$347.93	18	$363.88
19	$489.79	19	$475.63	19	$463.85	19	$358.60	19	$375.04
20	$504.88	20	$490.29	20	$478.14	20	$369.65	20	$386.60
21	$520.50	21	$505.45	21	$492.93	21	$381.08	21	$398.56
22	$520.50	22	$505.45	22	$492.93	22	$381.08	22	$398.56
23	$520.50	23	$505.45	23	$492.93	23	$381.08	23	$398.56
24	$520.50	24	$505.45	24	$492.93	24	$381.08	24	$398.56
25	$522.58	25	$507.48	25	$494.90	25	$382.61	25	$400.15
26	$532.99	26	$517.59	26	$504.76	26	$390.23	26	$408.12
27	$545.48	27	$529.72	27	$516.59	27	$399.37	27	$417.69
28	$565.78	28	$549.43	28	$535.82	28	$414.23	28	$433.23
29	$582.44	29	$565.60	29	$551.59	29	$426.43	29	$445.99
30	$590.77	30	$573.69	30	$559.48	30	$432.53	30	$452.36
31	$603.26	31	$585.82	31	$571.31	31	$441.67	31	$461.93
32	$615.75	32	$597.95	32	$583.14	32	$450.82	32	$471.49
33	$623.56	33	$605.53	33	$590.53	33	$456.53	33	$477.47
34	$631.89	34	$613.62	34	$598.42	34	$462.63	34	$483.85
35	$636.05	35	$617.66	35	$602.36	35	$465.68	35	$487.04
36	$640.21	36	$621.71	36	$606.31	36	$468.73	36	$490.23
37	$644.38	37	$625.75	37	$610.25	37	$471.78	37	$493.41
38	$648.54	38	$629.79	38	$614.19	38	$474.83	38	$496.60
39	$656.87	39	$637.88	39	$622.08	39	$480.92	39	$502.98
40	$665.20	40	$645.97	40	$629.97	40	$487.02	40	$509.36
41	$677.69	41	$658.10	41	$641.80	41	$496.17	41	$518.92
42	$689.66	42	$669.73	42	$653.13	42	$504.93	42	$528.09
43	$706.32	43	$685.90	43	$668.91	43	$517.12	43	$540.84
44	$727.14	44	$706.12	44	$688.62	44	$532.37	44	$556.78
45	$751.60	45	$729.87	45	$711.79	45	$550.28	45	$575.52
46	$780.75	46	$758.18	46	$739.40	46	$571.62	46	$597.84
47	$813.54	47	$790.02	47	$770.45	47	$595.63	47	$622.94
48	$851.01	48	$826.41	48	$805.94	48	$623.06	48	$651.64
49	$887.97	49	$862.30	49	$840.94	49	$650.12	49	$679.94
50	$929.61	50	$902.74	50	$880.37	50	$680.61	50	$711.82
51	$970.73	51	$942.67	51	$919.31	51	$710.71	51	$743.31
52	$1,016.01	52	$986.64	52	$962.20	52	$743.87	52	$777.98
53	$1,061.81	53	$1,031.12	53	$1,005.58	53	$777.40	53	$813.06
54	$1,111.26	54	$1,079.14	54	$1,052.41	54	$813.60	54	$850.92
55	$1,160.71	55	$1,127.16	55	$1,099.23	55	$849.80	55	$888.78
56	$1,214.32	56	$1,179.22	56	$1,150.00	56	$889.05	56	$929.83
57	$1,268.45	57	$1,231.78	57	$1,201.27	57	$928.69	57	$971.28
58	$1,326.23	58	$1,287.89	58	$1,255.98	58	$970.99	58	$1,015.52
59	$1,354.85	59	$1,315.69	59	$1,283.10	59	$991.95	59	$1,037.44
60	$1,412.63	60	$1,371.79	60	$1,337.81	60	$1,034.24	60	$1,081.68
61	$1,462.60	61	$1,420.32	61	$1,385.13	61	$1,070.83	61	$1,119.94
62	$1,495.39	62	$1,452.16	62	$1,416.19	62	$1,094.84	62	$1,145.05
63	$1,536.51	63	$1,492.09	63	$1,455.13	63	$1,124.94	63	$1,176.54
64 +	$1,561.49	64 +	$1,516.35	64 +	$1,478.79	64 +	$1,143.23	64 +	$1,195.67

Alliance Health and Life Insurance Company

Alliance Health and Life Insurance Company (Alliance)
Preferred Provider Organization (PPO)
Summary of Benefits
HAP PPO Gold B12 **PPO**
PPQ02092 / XRQ03027

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,200 Individual; $2,400 Family	$3,000 Individual; $6,000 Family	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	0%	50%	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$7,000 Individual; $14,000 Family	$20,000 Individual; $40,000 Family	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	$35 Copay - Deductible does not apply	50% Coinsurance after deductible	
Telehealth Visit	Covered - Deductible does not apply	Not Covered	Through our contracted telehealth services provider.
Specialist Office Visit	$60 Copay - Deductible does not apply	50% 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	$30 Copay - Deductible does not apply	50% Coinsurance after deductible	Manipulation of spine for subluxation only. Up to 20 visits per benefit period (Combined In and Out-of-Network).
Allergy Treatment	Covered after deductible	50% Coinsurance after deductible	
Allergy Injections	Covered after deductible	50% Coinsurance after deductible	
Laboratory & Pathology	$45 Copay per test - Deductible does not apply	50% Coinsurance after deductible	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after deductible	50% Coinsurance after deductible	Services require preauthorization.
Radiology (X-ray)	$45 Copay per test - Deductible does not apply	50% Coinsurance after deductible	
Radiation Therapy & Chemotherapy	Covered after deductible	50% Coinsurance after deductible	
Dialysis	Covered after deductible	50% Coinsurance after deductible	Out-of-Network benefits are not covered unless Prior Authorized.
Outpatient Medical Drugs	20% Coinsurance after deductible	50% Coinsurance after deductible	
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	50% Coinsurance after deductible	
Ambulatory Surgical Center	Covered after deductible	50% Coinsurance after deductible	
Professional Surgical and Related Services	Covered after deductible	50% Coinsurance after deductible	
Emergency/Urgent Care			
Urgent Care	$65 Copay - Deductible does not apply		
Emergency Room Care	$300 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	$100 Copay - Deductible does not apply		Emergency transport only
Inpatient Hospital Services			
Facility Fee	Covered after deductible	50% Coinsurance after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	50% Coinsurance after deductible	
Bariatric Surgery and Related Services	Covered after deductible	Not Covered	One procedure per lifetime

Maternity Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	Not Covered	Covered under Preventive Services. For non-routine visits see Specialist Office Visit.
Routine Postnatal Office Visits	Covered - Deductible does not apply	Not Covered	Covered under Preventive Services. For non-routine visits see Specialist Office Visit.
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	$35 Copay - Deductible does not apply	50% Coinsurance after deductible	
Other Services			
Home Health Care	Covered after deductible	50% Coinsurance after deductible	Does not include Rehabilitation Services. Unlimited.
Hospice Care	Covered after deductible	50% Coinsurance after deductible	Unlimited.
Skilled Nursing Care	Covered after deductible	50% Coinsurance after deductible	Covered for authorized services. Up to 45 days per benefit period (Combined In and Out-of-Network).
Durable Medical Equipment; Prosthetics & Orthotics	Covered after deductible	50% Coinsurance after deductible	Covered for approved equipment only.
Vision Hardware	Covered - Deductible does not apply	Not Covered	Covered once each benefit period through HAP's Contracted Providers for Pediatric Members only. Detailed information regarding coverage of lenses, Collection Frames, and Collection Contacts can be found in your policy or plan documents.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$45 Copay - Deductible does not apply	50% Coinsurance after deductible	May be rendered at home.Rehabilitative Physical Therapy and Occupational Therapy up to 30 combined visits per benefit period. Rehabilitative Speech Therapy up to 30 visits per benefit period. (Combined In-Network and Out-of-Network)
Habilitation Services: Physical, Occupational, and Speech Therapy	$45 Copay - Deductible does not apply	50% Coinsurance after deductible	Physical and Occupational Therapy up to 30 combined visits per benefit period. Speech Therapy up to 30 visits per benefit period. Services may be rendered in the home. (Combined In and Out-of-Network). Limits and OON benefits do not apply for treatment of autism.
Applied Behavioral Analysis	$35 Copay - Deductible does not apply	Not Covered	Limited to services associated with the treatment of Autism Spectrum Disorders. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	See Outpatient Surgical Services	Limited to vasectomy.
Infertility Services	Covered after deductible	50% Coinsurance after deductible	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	Covered after deductible	Not Covered	
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$5 Copay 30 day supply, $10 Copay 90 day supply		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	$30 Copay 30 day supply, $60 Copay 90 day supply		
Preferred Brand Drugs	$40 Copay 30 day supply, $80 Copay 90 day supply		
Non Preferred Brand Drugs	$80 Copay 30 day supply, $160 Copay 90 day supply		
Preferred Specialty Drugs	20% Coinsurance ($200 max) 30 day supply at Specialty pharmacy only		
Non Preferred Specialty Drugs	50% Coinsurance ($500 max) 30 day supply at Specialty pharmacy only		

Template Rev 01/2020

- In case of conflict between this summary and your PPO Group Health Insurance Policy and Riders, the terms and conditions of the PPO Group Health Insurance Policy and Riders will govern. This 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, they will be processed 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 any 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.
- PPO plans are offered through Alliance health and Life Insurance Company, a wholly owned subsidiary of health Alliance Plan.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2024 - 12/31/2024

Alliance Health and Life Insurance Company **HAP PPO Gold B12**

Coverage for: Individual + Family | Plan Type: PPO

PPQ02092 XRQ03027

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 1-800-944-9399 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 1-800-944-9399 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**IN-NETWORK** **$1,200** individual / **$2,400** family. **OUT-OF-NETWORK** **$3,000** individual / **$6,000** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency Services, Urgent care, Emergency Medical Transportation, Lab Pathology, Radiology, Chiropractic, Vision Hardware, Office Visits, Preventive services, Rehabilitation Services, Pharmacy	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**IN-NETWORK:** **Out-of-Pocket Limit:** **$7,000** individual/ **$14,000** family. **OUT-OF-NETWORK:** **Out-of-Pocket Limit:** **$20,000** individual/ **$40,000** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover. All other cost share accumulates unless otherwise specified in Plan Documents.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.hap.org or call 1-800-944-9399 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	$35 Copay; deductible does not apply	50% Coinsurance after deductible	
	Specialist visit	$60 Copay; deductible does not apply	50% Coinsurance after deductible	
	Other practitioner office visit	Telehealth Visit: No Charge; deductible does not apply Chiropractic Visit: $30 Copay; deductible does not apply	50% 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 20 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)	$45 Copay per test; deductible does not apply	50% Coinsurance after deductible	Some services require preauthorization
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	50% 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	$5 Copay / prescription (retail); deductible does not apply	Not Covered	Costs shown apply to a 30-day supply of drugs. A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Applies to all Generic and Brand type drugs.
	Non-preferred Generic drugs	$30 Copay / prescription (retail); deductible does not apply	Not Covered	
	Preferred Brand drugs	$40 Copay / prescription (retail); deductible does not apply	Not Covered	
	Non-preferred Brand drugs	$80 Copay / prescription (retail); deductible does not apply	Not Covered	
	Preferred Specialty drugs	20% Coinsurance / prescription (retail); deductible does not apply	Not Covered	All specialty drugs are limited to a 30-day supply at a specialty pharmacy only. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a Copay or max is shown, You will pay 2 times that amount for a supply up to 60 days, and 3 times that amount for a supply of up to 90 days. Other exclusions & limitations may apply. 30 day supply: ($200 Max). Other exclusions & limitations may apply.
	Non-preferred Specialty drugs	50% Coinsurance / prescription (retail); deductible does not apply	Not Covered	30 day supply: ($500 Max). Other exclusions & limitations may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center(ASC))	No Charge after deductible	50% Coinsurance after deductible	Some services require preauthorization.
	Physician/surgeon fees	No Charge after deductible	50% Coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$300 Copay; deductible does not apply	$300 Copay; deductible does not apply	Copay will be waived if admitted
	Emergency medical transportation	$100 Copay; deductible does not apply	$100 Copay; deductible does not apply	Emergency transport only
	Urgent care	$65 Copay; deductible does not apply	$65 Copay; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	50% Coinsurance after deductible	Elective hospital admissions require that Alliance be notified prior to the admission. Alliance must be notified within 48 hours of any emergency hospital admission. Failure to notify Alliance could result in nonpayment of benefits.
	Physician/surgeon fees	No Charge after deductible	50% Coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 Copay; deductible does not apply	50% 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	No Charge after deductible	50% 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.For non-routine visits see Specialist Office Visit.
	Childbirth/delivery professional services	No Charge after deductible	50% Coinsurance after deductible	
	Childbirth/delivery facility services	No Charge after deductible	50% 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	No Charge after deductible	50% Coinsurance after deductible	Does not include Rehabilitation Services. Unlimited.
	Rehabilitation services	$45 Copay; deductible does not apply	50% Coinsurance after deductible	May be rendered at home. Rehabilitative Physical Therapy and Occupational Therapy up to 30 combined visits per benefit period. Rehabilitative Speech Therapy up to 30 visits per benefit period. (Combined In-Network and Out-of-Network)
	Habilitation services	$45 Copay; deductible does not apply	50% Coinsurance after deductible	Physical and Occupational Therapy up to 30 combined visits per benefit period. Speech Therapy up to 30 visits per benefit period. Services may be rendered in the home. (Combined In and Out-of-Network). Limits and OON benefits do not apply for treatment of autism. See Outpatient Mental Health for ABA cost sharing amount.
	Skilled nursing care	No Charge after deductible	50% Coinsurance after deductible	Covered for authorized services. Up to 45 days per benefit period (Combined In-Network and Out-of-Network).
	Durable medical equipment	No Charge after deductible	50% Coinsurance after deductible	Covered for approved equipment only
	Hospice services	No Charge after deductible	50% Coinsurance after deductible	Unlimited.
If your child needs dental or eye care	Children's eye exam	$60 Copay; deductible does not apply	50% Coinsurance after deductible	One routine eye exam per benefit period at no cost share. Routine exam not covered Out-of-Network.
	Children's glasses	No Charge; deductible does not apply	Not Covered	Covered once each benefit period through HAP's Contracted Providers for Pediatric Members only. Detailed information regarding coverage of lenses, Collection Frames, and Collection Contacts can be found in your policy or plan documents.
	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	• Voluntary Termination of Pregnancy	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery	• Chiropractic Care	• Infertility Treatment
• Routine Eye Care (Adult)	• Routine Foot Care	• 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 1-800-944-9399 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 1-800-944-9399; 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	$1,200	■ The plan's overall deductible	$1,200	■ The plan's overall deductible	$1,200
■ Specialist copayment	$60	■ Specialist copayment	$60	■ Specialist copayment	$60
■ Hospital (facility)	$0	■ Hospital (facility)	$0	■ Hospital (facility)	$0
■ Other coinsurance	0%	■ Other coinsurance	0%	■ Other coinsurance	0%
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits (*prenatal care*)		Primary care physician office visits (*including disease education*)		Emergency room care (*including medical supplies*)	
Childbirth/Delivery Professional Services		Diagnostic tests (*blood work*)		Diagnostic tests (*x-ray*)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (*crutches*)	
Diagnostic tests (*ultrasounds and blood work*)		Durable medical equipment (*glucose meter*)		Rehabilitation services (*physical therapy*)	
Specialist visit (*anesthesia*)					
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	$1,200	Deductibles	$790	Deductibles	$290
Copayments	$599	Copayments	$1,153	Copayments	$955
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
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	**$1,860**	**The total Joe would pay is**	**$1,965**	**The total Mia would pay is**	**$1,245**

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 bezplatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 lub TTY: 711.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь по номеру (800) 422-4641 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte (800) 422-4641 ili tekstualni telefon za osobe oštećena sluha: 711.

ATENCIÓN: si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Llame al (800) 422-4641, los usuarios TTY deben llamar al 711.

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

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Tumawag sa (800) 422-4641 o TTY: 711.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi (800) 422-4641 hoặc TTY: 711.