



**Mott Community College  
HealthPlus PPO Plan  
Explanation of Special Medical Reimbursement Benefits**

**To:** All Eligible Employees of Mott Community College

**Re:** Group Health Plan Benefits

**Effective:** July 1, 2011

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**Medical Coverage:** HealthPlus PPO Plan #LT \$1,250/\$2,500 with Mott Community College's Special Medical Reimbursement Program to the benefit level of a modified HealthPlus PPO 1.

**EHIM:** Employee Health Insurance Management is the Claims Administrator of the Special Medical Reimbursement Program.

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***Your Current Benefits***

You are enrolled in a Preferred Provider Organization (PPO) Plan with benefits being paid by two parties, HealthPlus and your employer. Under this option, there is a \$1,250 per person/\$2,500 per family deductible if an in-network provider is used. After the deductible is met, if an in-network provider is used, HealthPlus will then pay 100% of most claims.

An in-network provider is any facility, physician, or laboratory that participates with the HealthPlus in their PPO network.

After HealthPlus processes your claim, your employer will be sharing in payments of claims as outlined in the chart below:

**IN-NETWORK BENEFITS**

**SINGLE COVERAGE**

Annual Deductible	\$1,250.00
Employee responsible for	\$0.00
Employer pays entire	\$1,250.00
Employee out-of-pocket expense	\$0.00

**TWO PERSON OR FAMILY COVERAGE**

Annual Deductible	\$2,500.00
Employee responsible for	\$0.00
Employer pays entire	\$2,500.00
Employee out-of-pocket expense	\$0.00

**OUT-OF-NETWORK BENEFITS**

**SINGLE COVERAGE**

Annual Deductible	\$250.00
Employee responsible for entire	\$250.00

**TWO PERSON OR FAMILY COVERAGE**

Annual Deductible	\$500.00
Employee responsible for entire	\$500.00

Annual Coinsurance	\$8,750.00
Employee pays entire 20%	\$1,750.00
HealthPlus pays 80% of \$8,750	\$7,000.00
Employee out-of-pocket expense	\$2,000.00

Annual Coinsurance	\$17,500.00
Employee pays entire 20%	\$3,500.00
HealthPlus pays 80% of \$17,500	\$14,000.00
Employee out-of-pocket expense	\$4,000.00

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Employee Health Insurance Management (EHIM) will process the amount that the Company will pay. HealthPlus will first process the claim and make any payment directly to the provider. HealthPlus will then forward the claim to EHIM who will determine if a second payment from the Company is required to insure there is no change in your current benefits with the new modified HealthPlus PPO 1 benefit design. EHIM merely processes claims and does not insure or underwrite any liabilities of the employer.

**Benefit Period/Maximum**

Your benefit period is a plan year. At your renewal date your deductible, coinsurance and special medical reimbursement start over.

**Deductible Amount**

**In-Network** Under the HealthPlus PPO Plan #LT program, you have a \$1,250 per person/\$2,500 per family in-network calendar year deductible. EHIM on behalf of Mott Community College will reimburse the entire \$1,250 per person/\$2,500 per family of the in-network deductible as each expense occurs.

**Out-of-Network** Under the HealthPlus PPO Plan #LT program, you have a \$250 per person/\$500 per family out-of-network calendar year deductible. You are responsible for the entire \$250 per person/\$500 per family of the out-of-network deductible as each expense occurs.

**Coinsurance Amount**

**In-Network** There is no in-network coinsurance for most services under this program.

**Out-of-Network** Once you have met the deductible; there is a 20% coinsurance on the next \$8,750 (\$1,750) per person/\$17,500 (\$3,500) per family maximum on all covered services. You are responsible for the entire \$1,750 per person/\$3,500 per family of the out-of-network coinsurance as each expense occurs.

**Benefits Paid at 100%**

Once you have met the deductible, HealthPlus will then pay 100% of most in-network claims for the remaining plan year.



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**Required Documentation**

In order for EHIM to consider your claim under the Special Medical Reimbursement Plan, EHIM must have completed and signed EHIM Authorization for Use and Disclosure of Protected Health Information (PHI) form on file for you. EHIM will receive electronic files of your finalized claims from HealthPlus and will use the claims detail received to determine if reimbursement is applicable under the Special Medical Reimbursement program.

**Employee Reimbursement**

As your claims are processed, you will receive from EHIM a Simplified Benefit Summary outlining how the claim was processed. If you are eligible to receive reimbursement under the Special Medical Reimbursement program, **EHIM will cut a check directly to your provider whenever possible.**

**HealthPlus Benefits-at-a-Glance**

The Benefits Summary provides you with a summary of the coverage you have with HealthPlus. This is only a summary and will not provide complete details regarding your coverage. For complete details regarding your coverage, please refer to your HealthPlus employee benefits booklet.

**Plan Modification, Amendment, and Termination**

Your Employer may modify, amend, or terminate (in whole or in part) the Special Medical Reimbursement Program, retroactively or prospectively, at any time in its sole discretion without prior notice to you or to any other covered individuals or their beneficiaries. The Plan Administrator will notify you of any modifications, amendments, or terminations that affect you.

**Program Funding and Asset Distribution Upon Termination**

Your Employer funds the Special Medical Reimbursement Program through its general assets and any employee contributions that your Employer may require. In case of Program termination, there are no specific assets set aside to use to pay claims incurred prior to the date of such termination. If the Special Medical Reimbursement Program is terminated as to all or any of the covered individuals or beneficiaries, benefits will only be paid to the affected individuals for claims incurred before the date of termination and only to the extent the Special Medical Reimbursement Program is then funded or the claims are paid by your Employer.

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**State of Michigan Disclosure Requirement**

The benefits under the Special Medical Reimbursement Program are self-funded benefits. Covered individuals under this Special Medical Reimbursement Program and their beneficiaries are not insured. In the event that benefit expenses that are eligible for payment under this Special Medical Reimbursement Program are not paid for any reason, you may be liable for those expenses. The Claims Supervisor, EHIM, merely processes claims and does not ensure that any of your benefit expenses will be paid.

**Errors**

If you receive a benefit which you are not entitled to under the Special Medical Reimbursement Program, for example as a result of an error, you are not entitled to keep the benefit but must instead return the benefit payment to EHIM as Claims Administrator or to the Plan Administrator.

**Overpayments**

An overpayment occurs if the Special Medical Reimbursement Program pays you an amount that is not payable under the Special Medical Reimbursement Program, if the Special Medical Reimbursement Program pays an expense or benefit more than once, or if all or part of an expense or benefit is paid by both the Special Medical Reimbursement Program and a third party and the total benefits and reimbursements you receive exceed the amount of the expense. An expense or benefit is considered paid if it is paid to you or to someone else (*e.g.* a health care provider) on your behalf.

If the Special Medical Reimbursement Program makes an overpayment, the Special Medical Reimbursement Program has the right to recover the overpayment. If the overpayment was made to a health care provider, the Special Medical Reimbursement Program may request a refund of the overpayment from either you or the provider. If the refund is not received from either you or the provider, the overpayment will be deducted from future Program benefits available to you or your beneficiaries or from your wages, but the amounts withheld will not reduce your pay below the applicable state or federal minimum wage unless permitted by law.

Any overpayment you owe due to you or your dependant's ineligibility for Program benefits will be offset by the amount of any contributions your Employer required you to make for that person while you or they were ineligible.



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**Administration of the Special Medical Reimbursement Program**

Your Employer is the Plan Administrator, but may delegate this responsibility to a person or persons designated by your Employer. The Plan Administrator must supply you with this Explanation and other information and to file various reports and documents regarding the Special Medical Reimbursement Program with government agencies. In its role of administering the Program, the Plan Administrator (or its delegate) also may make rulings, interpret the Plan, set procedures, gather needed information, receive and review financial information regarding the Special Medical Reimbursement Program, employ or appoint individuals to assist in any administrative function, and generally do all other things which need to be handled in administering the Plan. The Plan Administrator has retained the Claims Administrator, EHIM, merely to process claims and has not given EHIM authority to make final determinations about the benefits covered under the Special Medical Reimbursement Program nor about the administration of the Special Medical Reimbursement Program.

The Plan Administrator (or its delegate) shall have any and all powers of authority which shall be proper to enable it to carry out its duties under the Special Medical Reimbursement Program, including by way of illustration and not of limitation: (i) the power and authority contemplated by ERISA with respect to employee welfare plans; (ii) the powers and authority to make regulations with respect to the Plan not inconsistent with the Special Medical Reimbursement Program or ERISA; and (iii) the power and authority to determine, consistently therewith, all questions that may arise as to the status and rights of covered individuals and their beneficiaries and any and all other persons.

The Plan Administrator (or its delegate) also shall have full discretionary authority to interpret all provisions of the Special Medical Reimbursement Program, including resolving an inconsistency or ambiguity or correcting an error or an omission. The Special Medical Reimbursement Program shall be governed by and interpreted according to ERISA and the Internal Revenue Code and, where not preempted by Federal law, the laws of the State of Michigan. Subject to the provisions of the Plan, the actions and determinations by the Plan Administration (or its delegate) and the interpretation or construction of any provision of the Special Medical Reimbursement Program by the Plan Administrator (or its delegate) shall be final and conclusive upon all affected individuals or entities.

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**Information Disclaimer**

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**Questions Regarding your Benefits**

If at any time you have questions regarding your benefits, please feel free to call EHIM at 1-855-396-1159 or e-mail us at [Medicalclaims@ehimrx.com](mailto:Medicalclaims@ehimrx.com). You may also contact HEALTHPLUS directly at 1-800-332-9161.

26711 Northwestern Highway, Suite 400  
Southfield, MI 48033

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**HealthPlus/EHIM**  
**Explanation of Special Medical Reimbursement Benefits**

WHEN HEALTHPLUS PROCESSES A CLAIM, THEY WILL SEND TO YOU AN EXPLANATION OF BENEFITS (EOB). THE EOB IS A WRITTEN EXPLANATION OF HOW HEALTHPLUS PROCESSES A CLAIM. THE EOB WILL INDICATE WHETHER HEALTHPLUS HAS APPROVED, REJECTED, OR IS REVIEWING THE CLAIM FURTHER.

AFTER HEALTHPLUS HAS MADE A DETERMINATION REGARDING YOUR CLAIM, EHIM WILL REVIEW IT TO SEE IF YOUR CLAIM MAY BE ELIGIBLE FOR ADDITIONAL BENEFITS UNDER THE MOTT COMMUNITY COLLEGE SPECIAL MEDICAL REIMBURSEMENT PROGRAM. YOU WILL RECEIVE AN EHIM SIMPLIFIED BENEFIT SUMMARY INDICATING WHETHER OR NOT YOUR CLAIM QUALIFIES FOR ADDITIONAL BENEFITS.

A SAMPLE COPY OF AN EHIM SIMPLIFIED BENEFIT SUMMARY IS SHOWN ON THE NEXT PAGE.

**HEALTHPLUS WILL AUTOMATICALLY SEND AN ELECTRONIC FILE OF YOUR FINALIZED CLAIMS DIRECTLY TO EHIM.**

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# Simplified Benefit Summary <sup>TM</sup>

123456

July 1, 2011

Employee Name  
Employee Address

Re: Claimant Name

- Provider Name is a participating provider with HealthPlus, therefore you are not responsible for the RC above HealthPlus' approved amount.
- You are responsible for the balance.
- If you have not already done so, please send Provider Name payment of Out-of-Network Ded2 when you receive the bill. Remember to include your account number. If you have any questions about this or any other claim, please call us at (248) 948-9900. Thank you.

<b>Provider:</b>	Provider Name		
<b>Date of Service:</b>	Date Of Service		
<b>Charged Amount:</b>	Charged Amount		
<b>Approved Amount:</b>	Approved Amount		
<b>Deductible:</b>	Ded1	of which	(1) <b>Employee Deductible:</b> Ded2
			(2) <b>Employee Deductible:</b> Ded3
			(3) <b>Employer Deductible:</b> Ded4
<b>HealthPlus 80%:</b>	HP80		
<b>20% Copay:</b>	Copay1	of which	<b>Employee Copay:</b> Copay2
<b>Office Copay:</b>	OfficeCopay		(4) <b>Employer Copay:</b> Copay3
<b>HealthPlus 100%:</b>	HP100		
<b>Rejected Charges:</b>	Rejected		
<b>R &amp; C Fees:</b>	RC		
		<b>Employee Totals:</b>	<b>Total</b>
Processor Name		<b>Employer Totals:</b>	<b>Total1</b>

## YOUR CURRENT BENEFITS

You are enrolled in the HealthPlus PPO Plan #LT program. Under this program you have a \$1,250.00 per person/\$2,500.00 per family deductible. After the deductible and coinsurance have been met, HealthPlus will pay 100% of remaining claims for the calendar year. Please refer to your employee handbook for a summary of covered services and out-of-network benefits.

Mott Community College will be sharing in your in-network deductible costs as outlined in the charts below:

### SINGLE COVERAGE

<b>Annual Deductible In Network</b>	\$1,250.00
Employee pays	\$0.00
Employer pays entire	\$1,250.00
Employee Maximum Out-Of-Pocket (IN NET)	\$0.00

### TWO PERSON OR FAMILY COVERAGE

<b>Annual Deductible In Network</b>	\$2,500.00
Employee pays	\$0.00
Employer pays entire	\$2,500.00
Employee Maximum Out-Of-Pocket (IN NET)	\$0.00

**\*\* SEE EMPLOYEE HANDBOOK FOR DETAILS FOR OUT-OF-NETWORK CLAIMS \*\***

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## **HealthPlus**

### **Five Reasons to Choose a Participating Provider**

1. Participating physicians accept HealthPlus payment as payment in full.
2. You are not asked for payment at the time of service.
3. Your claims are filed for you.
4. You take an active part in holding down health care costs.
5. Participating physicians are easier to find than you think. Call the physician prior to your appointment to confirm that they accept your HealthPlus PPO Plan.

**HealthPlus pays claims based on their Reasonable & Customary Fee scale. Any amount above this scale may be your responsibility unless your providers participate with the HealthPlus PPO Program.**

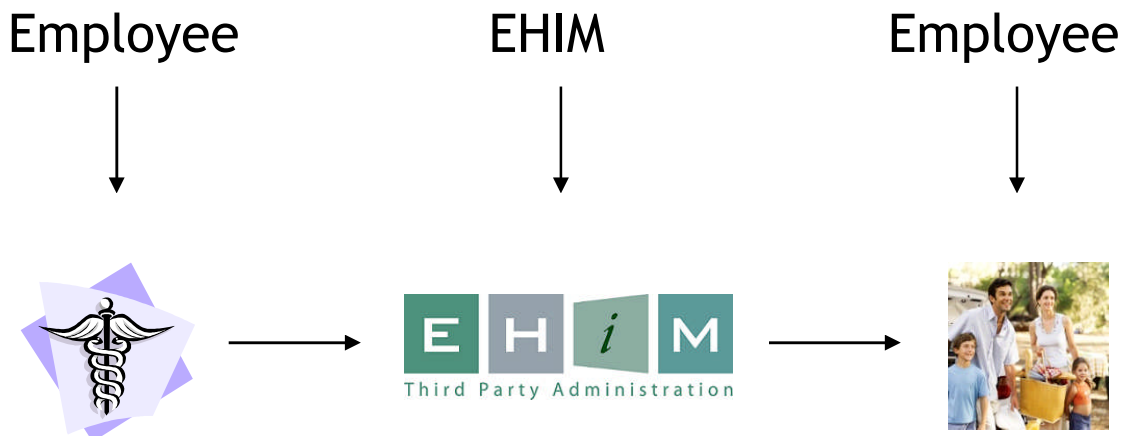
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# Special Medical Reimbursement Plan Overview

As a preferred partner, EHIM has a special program set up with HealthPlus which allows the employees' claims detail to come directly to EHIM in an electronic feed (EDI). Once EHIM receives this information, we determine whether the claim qualifies for any type of payment or reimbursement and issues payments/reimbursements accordingly.

Below is a brief description of how claims are processed.



### At the Provider

- Present your HealthPlus card

### Claims

- Receives EDI Claim from HealthPlus
- Reviews claim for additional payment and/or Member responsibility
- Sends EHIM Simplified Benefit Summary (SBS)
- Send payment to Provider or Member if applicable

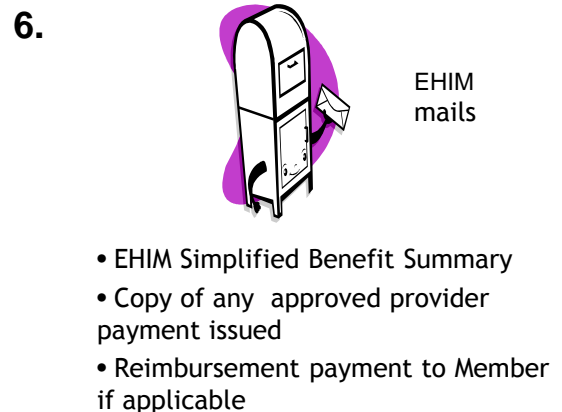
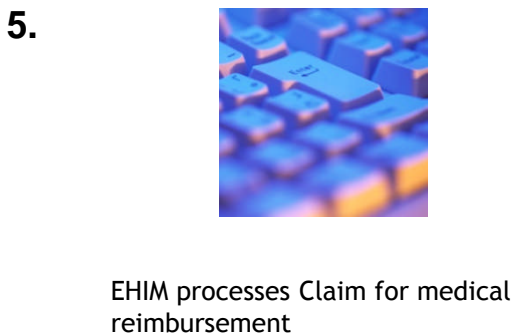
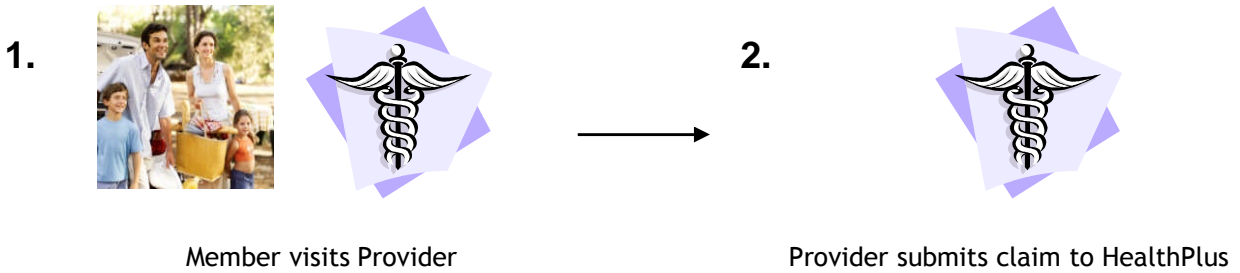
### At Home

- Receives HealthPlus EOB direct from HealthPlus
- Receives EHIM Simplified Benefit Summary and provider payment confirmation (if applicable)

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# Special Medical Reimbursement Plan Process



**EHIM MEDICAL CLAIMS CONTACT:**  
 Medical Claims Department  
 26711 Northwestern Hwy., #400  
 Southfield, MI 48033  
 Telephone: 855-396-1159  
 Fax: 248-945-4887

If you receive a bill before you receive a Simplified Benefit Summary from EHIM please call EHIM for assistance.