

PPO HRA Wrap Plan LT— Mott Community College (7/1/11)

Benefit Summary

This document is provided as an easy to read summary of your benefits. This Benefit Summary does not modify or take the place of your Schedule of Benefits, Certificate of Coverage or Benefit Riders. Please read your Schedule of Benefits, Certificate of Coverage and Benefit Riders for complete coverage details, benefit limitations and exclusions, and your cost sharing responsibility.

Services	Preferred Provider (In-Network) Member Responsibility	Non-Preferred Providers (Out-of- Network) Member Responsibility	
Deductible must be met for all services, including any services provided by optional rider, before HPI begins paying for services. The only exceptions are Immunizations and Routine Preventive Services listed below. .	Member is responsible for flat dollar Copays and/or percent Coinsurance shown below. Coinsurance dollar amounts are based on HealthPlus reimbursement rates for Covered services. Deductible must be met before coinsurance applies. Coinsurance: HealthPlus pays 100% Member Pays 0%	Member is responsible for flat dollar Copays and/or percent Coinsurance shown below. Coinsurance amounts are based on Allowed Amount for Covered services. Member is also responsible for any excess charges. Deductible must be met before coinsurance applies Coinsurance: HealthPlus pays 80% Member Pays 20%	
Deductible and Out-of-Pocket Maximum			
Deductible (applies to Out of Pocket Maximum)	Employer Pays: \$1,250 per Member; \$2,500 per Family	Member Pays: \$0	\$250 per Member; \$500 per Family
	<i>Deductible applies to all services except preventive. Benefits are not paid for Covered services until Deductible is met</i>		
Out-of-Pocket Maximum (OOP Max)-	Employer Pays: \$1,250 per Member; \$2,500 per Family	Member Pays: \$0	\$2,000 per Member; \$4,000 per Family
	<i>Deductible and coinsurance payments apply to OOP Maximum</i>		
Lifetime Maximum Benefits	No lifetime dollar limit.		
Routine Immunizations <i>Deductible does not apply to in-network services; see Certificate of Coverage for age restrictions and benefit limitations.</i>			
Routine Childhood Immunizations: up through age 18	Immunizations Covered at 100%	20% of allowed amount after Deductible plus any excess charges	
Adult Immunizations: Flu vaccine, Pneumonia vaccine, Tetanus/Diphtheria	Vaccines Covered at 100%		
Routine Preventive Services <i>Deductible does not apply to in-network services; see Certificate of Coverage for age restrictions and benefit limitations.</i>			
Adult Routine Health Maintenance Exam - one per benefit year beginning at age 18	Covered 100%	20% of allowed amount after Deductible plus any excess charges	
Adult Gynecological Exam - one per benefit year	Covered 100%		
Well-Baby and Well Child Care Visits: 7 Visits per benefit year through age 12 months. 6 Visits per benefit year ages 13-23 months 3 Visits per benefit year ages 24-47 months 1 Visit per benefit year ages 4-17 years <i>Copay applies to any additional visits.</i>	Covered 100%		
Childhood Screenings: Lead testing, Urinalysis Hemoglobin/Hemocrit	Lab tests Covered at 100%		
Cervical Cancer Screening Pap Smear—laboratory and pathology services—beginning at age 18	Labs Covered at 100%		
Breast Cancer Screening Mammogram	Mammogram Covered at 100%		
Colorectal Cancer Screening: <i>beginning at age 50</i>	Screening test Covered at 100%		
Diabetes Screening; <i>beginning at age 45</i>	Lab tests Covered at 100%		
Prostate Cancer Screening; PSA test; <i>at age 45</i>	Lab test and prostate exam Covered at 100%		
Physician Services—Office and Home Visits			
Office and Home Visits for Illness or Injury	100% Coverage after Deductible is met	20% of allowed amount after Deductible plus any excess charges	
Other Physician and Professional Services			
Hospital inpatient or outpatient Visits and/or consultations	100% Coverage after Deductible is met	20% of allowed amount after Deductible plus any excess charges	
Delivery and newborn nursery services	100% Coverage after Deductible is met		
All other physician and professional services including surgical and anesthesiology services	100% Coverage after Deductible is met		

Services	Member Responsibility – Preferred Providers	Member Responsibility – Non Preferred Providers
Emergency Medical Care		
Hospital Emergency Room (ER)	100% Coverage after Deductible is met	Employer pays In-Network Deductible
ER Physician/Professional Services	100% Coverage after Deductible is met	In Network Deductible/ Coinsurance apply
Urgent Care Center	100% Coverage after Deductible is met	Employer pays In-Network Deductible
Ambulance Services – medically necessary	100% Coverage after Deductible is met	In Network Deductible/ Coinsurance apply
Diagnostic Services		
Laboratory and Pathology Tests	\$0 copay -- deductible does not apply	20% of allowed amount after Deductible plus any excess charges
Diagnostic and Therapeutic Radiological Services	100% Coverage after Deductible is met	
Maternity Services Provided By a Physician <i>Certified Nurse Midwife Covered if He/She provides services under the direction of a physician; No home birth coverage</i>		
Pre-Natal and Post-Natal Care	100% Coverage after Deductible is met	20% of allowed amount after Deductible plus any excess charges
Delivery and Nursery Care	100% Coverage after Deductible is met	
Hospital Care <i>All elective hospitalizations and some outpatient procedures require HPM prior authorization; emergency admissions require notification within 24 hours. Copayment penalty applied to facility charges before benefits are paid if proper prior authorization processes are not followed</i>		
Inpatient Care including newborn nursery	100% Coverage after Deductible is met	20% of allowed amount after Deductible plus any excess charges
Outpatient Surgery, Other Services and Supplies	100% Coverage after Deductible is met	
Specific Human Organ / Tissue Transplants	100% Coverage after Deductible is met	100% Coverage after In-network Deductible is met when arranged through a HealthPlus approved provider.
Alternatives to Hospital Care <i>Prior authorization required for some of the following services</i>		
Skilled Nursing Facility (<i>Limited to 120 days per Member per benefit year</i>)	100% Coverage after Deductible is met	100% Coverage after In-network Deductible is met when arranged through a HealthPlus approved provider.
Hospice Care (Inpatient, residential and home hospice services)	100% Coverage after Deductible is met	
Home Health Care—(<i>custodial care is not Covered</i>)	100% Coverage after Deductible is met	
Mental Health and Substance Abuse Treatment <i>Limited to Medically Necessary Treatment</i>		
Inpatient Mental Health Care and Day Treatment	100% Coverage after Deductible is met	20% of allowed amount after Deductible plus any excess charges
Outpatient Mental Health Care	\$0 Copay after Deductible is met	
Inpatient Substance Abuse Care	100% Coverage after Deductible is met	
Outpatient Substance Abuse Treatment	\$0 Copay after Deductible is met	
Other Services <i>Some services in this section require prior authorization and/or have Visit limitations</i>		
Allergy Injections	100% Coverage after Deductible is met	20% of allowed amount after Deductible and any excess charges
Family Planning Services	100% Coverage after Deductible is met	
Infertility Services (<i>Restrictions apply</i>)	50% Coinsurance after Deductible	Not Covered
Outpatient Physical, Speech and Occupational Therapy (<i>limited to 120 combined visits per benefit year</i>)	100% Coverage after Deductible is met	20% of allowed amount after Deductible plus any excess charges
Durable Medical Equipment, Orthotic, and Prosthetic Devices	100% Coverage after Deductible is met	100% Coverage after In-network Deductible is met when arranged through a HealthPlus approved provider.
OPTIONAL SERVICES RIDERS		
Prescription Drug Rider (AZ10201X)	Generic: \$10; Brand \$20; Fertility 50%	Same as in-network plus excess charges
Chiropractic Rider (CIH38XTM)	Includes X-rays/Traction 38visits; \$0 copay after deductible is met	OON Deductible applies; then OON coinsurance
Hearing Aid (HEARHR35)	100% Coverage every 36 months	100% Coverage every 36 months
Private Duty Home Health Nursing (PRIVHRA)	Deductible applies; then coinsurance	OON Deductible applies; then OON coinsurance