PriorityHealth

HMO HSA 100% PLAN : Kentwood Public Schools

Coverage Period: 01/01/2015 - 12/31/2015

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

Coverage for: Subscriber/Dependent | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **PriorityHealth.com** or by calling **1-800-446-5674**.

Important Questions	Answers	Why this Matters
What is the overall deductible?	**$2,000** person/ **$4,000** family The deductible doesn't apply to preventive care. If you have more than one person on your plan, only the family deductible applies. This deductible can be satisfied by a single family member or a combination of family members.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **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.
Is there an out-of-pocket limit on my expenses?	Yes. **$4,000** person/ **$8,000** family	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 helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, services that exceed an annual day/visit limit, health care this plan doesn't cover, and co-insurance you pay for any non-essential health benefits. See plan documents for additional services that may not be included in the out-of-pocket limit.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See **PriorityHealth.com** **or call 1-800-446-5674** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	You don't need a referral to see a participating specialist. You do need a referral to see a non-participating specialist.	You can see the in-network **specialist** you choose without permission from this plan. This plan will pay some or all of the costs to see an out-of-network **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 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-446-5674** or visit us at **PriorityHealth.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 **www.dol.gov/ebsa/healthreform or www.cciio.cms.gov** or call 1-800-446-5674 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) 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 network **participating providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Events	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge/ visit	Not covered	Coverage includes services provided face-to-face, telephonically, or through secure electronic portal. Prescription drug co-pay may also apply when selected injectable drugs are provided. Prescription drugs for infertility treatment covered only with prescription drug rider. See the Schedule of Copayments and Deductibles for a complete list of certain surgeries and treatments. Prior Approval may be required. Dietitian services include visits *not* listed in Priority Health's Preventive Health Care Guidelines. These services are limited to 6 visits per contract year. Prior approval is required for all treatments of Autism Spectrum Disorder. See Habilitation Services below for additional information.
	Specialist visit	No charge/ visit	Not covered	
	Other practitioner office visit	•No charge/ visit for virtual visits •No charge/ visit for dietitian services •No charge/ visit allergy testing, serum & injections •50% co-insurance/ visit for family planning/ infertility services •50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery •No charge for each certain surgery	•Virtual visits not covered •Dietitian services not covered •Allergy testing, serum & injections not covered •Family planning/ infertility services not covered •Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery not covered •Certain surgeries not covered	
	Preventive care/screening/ immunization	No charge	Not covered	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Prior Approval required for certain radiology examinations.

Common Medical Events	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.priorityhealth.com/prog/pharmacy/pharmacy.cgi	Generic drugs	$10 co-pay/ retail prescription $10 co-pay/ mail order prescription	Not covered	Costs shown in the "Your Cost" columns apply to drugs on the approved drug list when obtained from a Participating Provider. Covers up to a 31-day supply (retail prescription); Covers up to a 90 day supply (mail order prescription) Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for three applicable Copayments at a retail Participating Pharmacy. 50% co-insurance/ prescription for infertility drugs. Your deductible must be satisfied before the prescription drug co-pay or co-insurance will apply. This includes specialty drugs.
	Preferred brand drugs	$40 co-pay/ retail prescription $40 co-pay/ mail order prescription	Not covered	
	Non-preferred brand drugs	$40 co-pay/ retail prescription $40 co-pay/ mail order prescription	Not covered	
	Preferred specialty drugs	$40 co-pay/ retail prescription	Not covered	----------none----------
	Non-Preferred specialty drugs	$40 co-pay/ retail prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge/ visit	Not covered	Including outpatient care, observation care and ambulatory surgery center care. Prior approval may be required. See the Schedule of Copayments and Deductibles for a complete list of certain surgeries and treatments. Prior approval is required for bariatric surgery, panniculectomy, rhinoplasty and septorhinopliasty. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fees	No charge/ visit	Not covered	
If you need immediate medical attention	Emergency room services	No charge/ visit	Covered at the in-network benefit level	----------none----------
	Emergency medical transportation	No charge	Covered at the in-network benefit level	----------none----------
	Urgent care	No charge/ visit	Covered at the in-network benefit level when obtained outside of the Service Area	Urgent Care services received from a Non-Participating Provider who is located in our Service Area are not Covered. Urgent Care services received from a Non-Participating Provider who is located outside of our Service Area are Covered.

Common Medical Events	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge/ visit	Not covered	Prior Approval is required at least 5 working days in advance, except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Notification must be provided for all admissions following emergency room care. See the Schedule of Copayments and Deductibles for a complete list of certain surgeries and treatments. Prior approval is required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fee	No charge/ visit	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge / visit	Not covered	Including medication management visits.
	Mental/Behavioral health inpatient services	No charge/ visit	Not covered	Including Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
	Substance use disorder outpatient services	No charge / visit	Not covered	Including medication management visits.
	Substance use disorder inpatient services	No charge/ visit	Not covered	Including subacute, Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
If you are pregnant	Routine prenatal and postnatal care	No Charge	Not covered	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.
	Delivery and all inpatient services	No charge/ visit	Not covered	Deductible applies to facility charges for delivery.

Common Medical Events	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions (All benefits apply after the deductible is met unless otherwise noted)
If you need help recovering or have other special health needs	Home health care	No charge/ visit	Not covered	Including hospice care services; excluding rehabilitation and habilitation services Prior Approval required except for hospice care services in the home. Rehabilitation and habilitation services provided in the home are subject to the limitations of the Rehabilitation Services and Habilitation Services benefits described below.
	Rehabilitation services These services are *not* for the treatment of Autism Spectrum Disorder	No charge/ visit	Not covered	Physical and occupational therapy (Including osteopathic and chiropractic manipulation) limited to a combined 30 visits per contract year. Speech therapy limited to 30 visits per contract year. Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 50 visits per contract year.
	Habilitation services for treatment of Autism Spectrum Disorder **only**	No charge/ visit	Not covered	Prior Approval required for all treatment of Autism Spectrum Disorder. Covered services include Physical, Occupational, and Speech Therapy and Applied Behavioral Analysis (ABA). Services are Covered for children and adolescents under age 19 only. Multiple charges may apply during one day of service.
	Habilitation services not for the treatment of Autism Spectrum Disorder	Not covered	Not covered	Not covered
	Skilled nursing care	No charge/ visit	Not covered	Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 90 days per contract year. Prior approval required.
	Durable medical equipment (DME)	50% co-insurance/ visit	Not covered	Including rental, purchase or repair. Prior Approval required for equipment over $1,000.
	Prosthetics & orthotics	50% co-insurance/ visit	Not covered	
	Hospice service	No charge/ visit	Not covered	This benefit applies to hospice services provided in the home only. Any hospice services provided in a facility will be subject to the appropriate facility benefit.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult & Child)	• Habilitation services not for the treatment of Autism Spectrum Disorder • Hearing aids • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult & Child) • Routine foot care

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	• Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility	• Weight loss programs • Emergency services provided outside the U.S.

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-800-446-5674. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Priority Health at 1-800-446-5674 or visit www.priorityhealth.com;
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); or
- The Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or **DIFS-HICAP@Michigan.gov**

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

NOTE: These examples demonstrate possible costs under Subscriber only coverage. If you have Subscriber/Dependent coverage, your costs may be different.

Having a baby

(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,390
- **Patient pays** $2,150

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	$2,000
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$150
Total	**$2,150**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,540
- **Patient pays** $2,860

Sample care costs:

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

Patient pays:

Deductibles	$2,000
Co-pays	$150
Co-insurance	$630
Limits or exclusions	$80
Total	**$2,860**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-389-6645.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-389-6645.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-389-6645.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-389-6645.

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.

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