

Armada Area Schools ~ Effective 01/01/2010
BENEFIT SUMMARY
PPO Enhanced Plan # 0P D200X1 8Q

This is 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 Member is responsible for flat dollar Copays and/or percent Coinsurance shown below. Deductible must be met before coinsurance applies Coinsurance: HealthPlus Pays 100% Member Pays 0%	Non-Preferred Providers (Out-of-Network) Member Responsibility Member is responsible for flat dollar Copays and/or percent Coinsurance shown below. 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)	\$200 per Member \$400 per Family	\$400 per Member \$800 per Family
Out-of-Pocket Maximum	\$200 per Member \$400 per Family	\$1,200 per Member \$2,400 per Family
Lifetime Maximum Benefits	\$5,000,000 per Member (In and Out-of-Network); additionally, each Transplant Type has a \$1,000,000 per Member limit.	
Routine Immunizations and Preventive Services <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%; Office Visit Copay may apply	20% of allowed amount after Deductible plus any excess charges
Adult Immunizations: Flu vaccine, Pneumonia vaccine, Tetanus/Diphtheria	Vaccines Covered at 100%; Office Visit Copay may apply	
Adult Routine Health Maintenance Exam—one per benefit year beginning at age 18	Office Visit Copay applies	
Adult Gynecological Exam—one per benefit year	Office Visit Copay applies	
Well-Baby and Well Child Care Visits	Office Visit Copay applies	
Childhood Screenings: Lead testing, Urinalysis and, Hemoglobin/Hemocrit	Lab tests covered at 100%	
Cervical Cancer Screening Pap Smear	Lab tests covered at 100%	
Breast Cancer Screening Mammogram--beginning at age 40	Mammogram covered at 100%	
Colorectal Cancer Screening: beginning at age 50	Screening test covered at 100%	
Diabetes Screening; beginning at age 45	Lab tests covered at 100%	
Prostate Cancer Screening; PSA test; beginning at age 45	Lab test and prostate exam covered at 100%	
Physician Services		
Office and Home Visits for Illness or Injury	Primary Care Physician Copay: \$20 Specialist Physician Copay: \$20	20% of allowed amount after Deductible plus any excess charges
Hospital inpatient or outpatient visits and/or consultations	100% Coverage after Deductible	
Delivery and newborn nursery services	100% Coverage after Deductible	
All other physician and professional services including surgical and anesthesiology services	100% Coverage after Deductible	
Emergency Medical Care		
Hospital Emergency Room (Copay waived if Member is admitted to the hospital)	Copay: \$50	Member pays In-Network Copay plus any Excess Charges
Emergency Room Physician/Professional Services	100% Coverage after Deductible	In-Network Deductible and Coinsurance apply

Services	Preferred Provider (In-Network) Member Responsibility	Non-Preferred Providers (Out-of-Network) Member Responsibility
Emergency Medical Care (continued)		
Freestanding Emergency Center or Urgent Care Center	Copay: \$20	Member pays In-Network Copay plus any Excess Charges
Ambulance Services – when medically necessary	100% Coverage after Deductible	In-Network Deductible and Coinsurance apply
Diagnostic Services		
Laboratory and Pathology Tests	QUEST LABS: \$0 Copay Other Preferred Providers: 100% Coverage after Deductible	20% of allowed amount after Deductible plus any excess charges
Diagnostic and Therapeutic Radiological Services	100% Coverage after Deductible	
Maternity Services Provided by a Physician <i>No home birth coverage; see Certificate of Coverage for Midwife coverage.</i>		
Pre-Natal and Post-Natal Care	100% Coverage (Office Visit Copay may apply for first Visit)	20% of allowed amount after Deductible plus any excess charges
Delivery and Nursery Care	100% Coverage after Deductible	
Hospital Care <i>Elective hospitalizations/some outpatient procedures require HPI prior authorization; Emergency admissions require authorization within 24 hours. Copayment penalty applies if no prior authorization. See Schedule of Benefits for copayment penalty dollar amount.</i>		
Inpatient care including newborn nursery	100% Coverage after Deductible	20% of allowed amount after Deductible plus any excess charges
Outpatient Surgery, Other Services and Supplies	100% Coverage after Deductible	
Alternatives to Hospital Care <i>See Schedule of Benefits and Certificate of Coverage for limitations and restrictions and Prior Authorization requirements.</i>		
Skilled Nursing Facility (120 days)	100% Coverage after Deductible	20% of allowed amount after Deductible plus any excess charges
Hospice Care (prior auth for inpatient)	100% Coverage after Deductible	
Home Health Care—(custodial care is not covered)	100% Coverage after Deductible	
Transplants <i>Prior authorization required; must be in designated facility; \$1 million lifetime limit per transplant type</i>		
Specific Human Organ / Tissue Transplants	100% Coverage after Deductible	Not Covered
Mental Health and Substance Abuse Treatment <i>See Schedule of Benefits and Certificate of Coverage for complete information on limitations, restrictions and exclusions. Limited to Medically Necessary treatment.</i>		
Inpatient Mental Health Care and Day Treatment (Limited to Medically Necessary treatment)	100% Coverage after Deductible	20% of allowed amount after Deductible plus any excess charges
Outpatient Mental Health (Prior authorization required after 30 Visits)	Primary Care Physician Office Visit Copay	
Inpatient Substance Abuse Care (Limited to Medically Necessary treatment)	100% Coverage after Deductible	
Outpatient Substance Abuse Treatment (Prior authorization required after 30 Visits)	Primary Care Physician Office Visit Copay	
Other Services <i>See Schedule of Benefits and Certificate of Coverage for limitations, restrictions and exclusions</i>		
Allergy Injections (Deductible does not apply)	Covered at 100% (Office Visit Copay may apply)	20% of allowed amount after Deductible plus any excess charges
Family Planning Services	100% Coverage after Deductible	
Infertility Services (Restrictions apply)	50% after Deductible (Copayments do not apply to out of pocket maximum)	Not Covered
Outpatient Physical, Speech and Occupational Therapy (Visit limits apply)	100% Coverage after Deductible	20% of allowed amount after Deductible plus any excess charges
Durable Medical Equipment, Orthotic and Prosthetic Devices	100% Coverage after Deductible	Not Covered (except breast prosthesis after mastectomy)
Optional Benefit Riders <i>Deductible Does Not Apply to Any Riders and Rider Copays Do Not Apply to Out-of-Pocket Maximum Please read Rider for complete coverage details including Benefit Limitations, Exclusions, and Copays or Coinsurance</i>		
Chiropractic Manipulations	\$10 Office Visit Copay; 24 Visits/benefit year	Same as in-network plus any excess charges
Hearing Aids	50% Copay; benefit limit of \$1,000 / benefit year	50% Copay; benefit limit of \$1,000 / benefit year
Private Duty Home Health Nursing	NOT COVERED	NOT COVERED
Prescription Drugs (prescription contraceptives are covered on all riders)	Rider 8Q: \$15 Generic Copay/prescription \$40 Brand Copay/prescription	Member must pay for prescriptions from Out-of-Network pharmacy and submit claim to HPI.