Base Plan

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits for
NEW PARADIGM FOR EDUCATION

AA000410 / ALTERNATE 1

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-Insurance Maximum:		
Benefit Period:	Calendar Year	
Annual Deductible	$1,000 Individual ; $2,000 Family	
Co-Insurance (amount member pays)	20%	
Annual Co-Insurance Maximum	$1,500 Individual ; $3,000 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover, penalties, deductibles, services with 50% coinsurance, and copays
Annual Out-of-Pocket Maximum	$6,350 Individual ; $12,700 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover, and penalties. All other cost-sharing accumulates.
Preventive Services:		
Preventive Office Visit / Physical Exam	Covered - Deductible does not apply	
Well Baby Office Visit	Covered - Deductible does not apply	Covered up to 24 months
Routine Hearing Exam	Covered - Deductible does not apply	
Routine Eye Exam	Covered - Deductible does not apply	
Immunizations	Covered - Deductible does not apply	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	
Pap Smears and Mammograms	Covered - Deductible does not apply	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	$30 Copay - Deductible does not apply	
Specialty Physician Office Visit	$30 Copay - Deductible does not apply	
Gynecology Office Visit	$30 Copay - Deductible does not apply	
Audiology Office Visit	$30 Copay - Deductible does not apply	
Eye Exam Office Visit	$30 Copay - Deductible does not apply	
Allergy Treatment and Injections	Plan Pays 80% after Deductible	
Laboratory and Radiology Services	Plan Pays 80% after Deductible	
Dialysis	Plan Pays 80% after Deductible	
Chemotherapy	Plan Pays 80% after Deductible	
Radiation Therapy	Plan Pays 80% after Deductible	
Outpatient Surgery	Plan Pays 80% after Deductible	
Chiropractic Office Visit and Related Services	$30 Copay - Deductible does not apply	Up to 10 visits per benefit period
Emergency/Urgent Care:		
Emergency Room Services	$250 Copay - Deductible does not apply	Copay will be waived if admitted
Urgent Care Facility Services	$30 Copay - Deductible does not apply	
Emergency Ambulance Services	Plan Pays 80% after Deductible	Emergency transport only
Inpatient Hospital Services:		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Plan Pays 80% after Deductible	
Bariatric Surgery & Related Services	Plan Pays 80% after Deductible	One procedure per lifetime
Maternity Services:		
Initial Prenatal Office Visit	Covered - Deductible does not apply	
Subsequent Prenatal Office Visits	Covered - Deductible does not apply	
Postnatal Office Visits	$30 Copay - Deductible does not apply	
Labor, Delivery and Newborn Care	Plan Pays 80% after Deductible	
Mental Health:		
Inpatient Services	Plan Pays 80% after Deductible	
Outpatient Services	$30 Copay - Deductible does not apply	
Chemical Dependency:		
Inpatient Services	Plan Pays 80% after Deductible	
Outpatient Services	$30 Copay - Deductible does not apply	
Other Services:		
Home Health Care	Plan Pays 50% after Deductible	Up to 60 visits per benefit period - See PT/OT/ST Coverage
Hospice Care	Plan Pays 80% after Deductible	Up to 210 days per lifetime
Skilled Nursing Care	Plan Pays 50% after Deductible	Covered for authorized services - Up to 100 days per benefit period
Durable Medical Equipment; Prosthetic & Orthotics	Plan Pays 50% after Deductible	Coverage provided for approved equipment based on HAP's guidelines
Hearing Aid Hardware	Not Covered	
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Plan Pays 80% after Deductible	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Plan Pays 80% after Deductible	
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Plan Pays 80% after Deductible	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Not Covered	
Pharmacy:		
Generic and Brand	Not Covered	

Value Plus

Rev 08/2012

Benefit Riders: 070,132,134,148,170,201,356,586,599,K06,K20

* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.

* Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.

* In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.

* Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.

S = 88.59
Y+1 = 201.63
Fam = 287.60

Per pay Deductions

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits for

Base Plan

AA002106

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:		
Benefit Period:	Calendar Year	
Annual Deductible	$1,000 Individual ; $2,000 Family	
Co-insurance (amount member pays)	20%	
Annual Co-insurance Maximum	$1,500 Individual ; $3,000 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover,deductibles,services with 50% coinsurance, and copays
Annual Out-of-Pocket Maximum	$6,600 Individual ; $13,200 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover. All other cost-sharing accumulates.
Preventive Services:		
Preventive Office Visit / Physical Exam	Covered - Deductible does not apply	
Well Baby Office Visit	Covered - Deductible does not apply	
Routine Hearing Exam	Covered - Deductible does not apply	
Routine Eye Exam	Covered - Deductible does not apply	
Immunizations	Covered - Deductible does not apply	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	
Pap Smears and Mammograms	Covered - Deductible does not apply	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	$30 Copay - Deductible does not apply	
Specialty Physician Office Visit	$30 Copay - Deductible does not apply	
Gynecology Office Visit	$30 Copay - Deductible does not apply	
Audiology Office Visit	$30 Copay - Deductible does not apply	
Eye Exam Office Visit	$30 Copay - Deductible does not apply	
Allergy Treatment and Injections	Plan Pays 80% after Deductible	
Laboratory and Radiology Services	Plan Pays 80% after Deductible	
Dialysis	Plan Pays 80% after Deductible	
Chemotherapy	Plan Pays 80% after Deductible	
Radiation Therapy	Plan Pays 80% after Deductible	
Outpatient Surgery	Plan Pays 80% after Deductible	
Chiropractic Office Visit and Related Services	$30 Copay - Deductible does not apply	Up to 10 visits per benefit period
Emergency/Urgent Care:		
Emergency Room Services	$250 Copay - Deductible does not apply	Copay will be waived if admitted
Urgent Care Facility Services	$30 Copay - Deductible does not apply	
Emergency Ambulance Services	Plan Pays 80% after Deductible	Emergency transport only
Inpatient Hospital Services:		
Hospital Inpatient Stay In Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Plan Pays 80% after Deductible	
Bariatric Surgery & Related Services	Plan Pays 80% after Deductible	One procedure per lifetime
Maternity Services:		
Initial Prenatal Office Visit	Covered - Deductible does not apply	Covered under Preventive Services
Subsequent Prenatal Office Visits	Covered - Deductible does not apply	Covered under Preventive Services
Postnatal Office Visits	$30 Copay - Deductible does not apply	
Labor, Delivery and Newborn Care	Plan Pays 80% after Deductible	
Mental /Behavioral Health:		
Inpatient Services	Plan Pays 80% after Deductible	
Outpatient Services	$30 Copay - Deductible does not apply	
Substance Use Disorder:		
Inpatient Services	Plan Pays 80% after Deductible	
Outpatient Services	$30 Copay - Deductible does not apply	
Other Services:		
Home Health Care	Plan Pays 50% after Deductible	Up to 60 visits per benefit period - See PT/OT/ST Coverage
Hospice Care	Plan Pays 80% after Deductible	Up to 210 days per lifetime
Skilled Nursing Care	Plan Pays 50% after Deductible	Covered for authorized services - Up to 100 days per benefit period
Durable Medical Equipment; Prosthetic & Orthotics	Plan Pays 50% after Deductible	Coverage provided for approved equipment based on HAP's guidelines
Hearing Aid Hardware	Not Covered	
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Plan Pays 80% after Deductible	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Plan Pays 80% after Deductible	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. **Women: Covered as Preventive Service**
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Plan Pays 80% after Deductible	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Not Covered	
Pharmacy:		
Generic and Brand	Not Covered	

Value Plus

Rev 08/2012

Benefit Riders: 070,132,134,148,170,201,356,586,599,K06,K60,MHE

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Buy up

Health Alliance Plan of Michigan

Health Maintenance Organization (HMO) Plan

Summary of Benefits for

NEW PARADIGM FOR EDUCATION

AA000410

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:		
Benefit Period:	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Preventive Services:		
Preventive Office Visit / Physical Exam	$30 Copay	
Well Baby Office Visit	$30 Copay	Covered up to 24 months
Routine Hearing Exam	$30 Copay	
Routine Eye Exam	$30 Copay	
Immunizations	Covered	
Related Laboratory and Radiology Services	Covered	
Pap Smears and Mammograms	Covered	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	$30 Copay	
Specialty Physician Office Visit	$30 Copay	
Gynecology Office Visit	$30 Copay	
Audiology Office Visit	$30 Copay	
Eye Exam Office Visit	$30 Copay	
Allergy Treatment and Injections	Covered	
Laboratory and Radiology Services	Covered	
Dialysis	Covered	
Chemotherapy	Covered	
Radiation Therapy	Covered	
Outpatient Surgery	Covered	
Chiropractic Office Visit and Related Services	$30 Copay	Up to 10 visits per benefit period
Emergency/Urgent Care:		
Emergency Room Services	$50 Copay	Copay will be waived if admitted
Urgent Care Facility Services	$30 Copay	
Emergency Ambulance Services	Covered	Emergency transport only
Inpatient Hospital Services:		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	
Bariatric Surgery & Related Services	$1,000 Copay	One procedure per lifetime
Maternity Services:		
Initial Prenatal Office Visit	$30 Copay	
Subsequent Prenatal Office Visits	$30 Copay	
Postnatal Office Visits	$30 Copay	
Labor, Delivery and Newborn Care	Covered	
Mental Health:		
Inpatient Services	Covered	
Outpatient Services	$30 Copay	
Chemical Dependency:		
Inpatient Services	Covered	
Outpatient Services	$30 Copay	
Other Services:		
Home Health Care	Plan Pays 50%	Up to 60 visits per benefit period - See PT/OT/ST Coverage
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Voluntary Sterilizations	Covered	
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Covered	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Not Covered	
Pharmacy:		
Generic and Brand	Not Covered	

Rev 08/2012

Benefit Riders: 034,070,131,132,134,170,176,201,599

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S = 102.92
Y+1 = 234.62
Fam = 339.79

Per part Deductions

Health Alliance Plan of Michigan

Health Maintenance Organization (HMO) Plan

Summary of Benefits for

AA000410

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:		
Benefit Period:	Calendar Year	
Annual Deductible	None	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	NA	
Annual Out-of-Pocket Maximum	$6,600 Individual ; $13,200 Family	These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover. All other cost-sharing accumulates.
Preventive Services:		
Preventive Office Visit / Physical Exam	$30 Copay	
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Outpatient & Physician Services:		
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Radiation Therapy	Covered	
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Urgent Care Facility Services	$30 Copay	
Emergency Ambulance Services	Covered	Emergency transport only
Inpatient Hospital Services:		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered	
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Maternity Services:		
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Postnatal Office Visits	$30 Copay	
Labor, Delivery and Newborn Care	Covered	
Mental /Behavioral Health:		
Inpatient Services	Covered	
Outpatient Services	$30 Copay	
Substance Use Disorder:		
Inpatient Services	Covered	
Outpatient Services	$30 Copay	
Other Services:		
Home Health Care	Plan Pays 50%	Up to 60 visits per benefit period - See PT/OT/ST Coverage
Hospice Care	Covered	Up to 210 days per lifetime
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Voluntary Sterilizations	Women: Covered Men: Plan Pays 100%	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. **Women: Covered as Preventive Service**
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Infertility Services	Covered	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Not Covered	
Pharmacy:		
Generic and Brand	Not Covered	

Rev 08/2012

Benefit Riders: 034,070,131,132,134,170,176,201,599,K60,MHE

* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.

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Heritage Vision Benefits Renewal

New Paradigm for Education

(Plan Number: 4051-00)

COVERED SERVICES	IN-NETWORK COVERAGE	OUT-OF-NETWORK REIMBURSEMENT
Comprehensive Eye Exam (Does not apply to Professional fees for Contact Lens Fitting)	100% Covered, **$5.00 Co-Pay**	Reimbursed up to **$30.00**
Frames:		
Frames (Members have Choice of Frames)	**$115.00** Retail Allowance, **No Co-pay** (Member pays all retail frame costs over **$115.00**)[2] *Covers All Wal-Mart / Sam's EDLP Frames up to Level 3 ($75)*	Reimbursed up to **$45.00**
Lenses (Per Pair): Choice of One *Covered Material = Standard Plastic CR-39*		
Single Vision	100% Covered, **$20.00 Co-Pay**	Reimbursed up to **$30.00**
Bifocal		Reimbursed up to **$40.00**
Trifocal		Reimbursed up to **$50.00**
Lenticular or Myodisc		Reimbursed up to **$70.00**
Lens Options & Upgrades:		
Progressive "No-Line" Upgrade (Upgrade from covered "lined" Trifocal lenses) $20.00 Lens Co-pay applies	A **20% Preferred Pricing Discount**[2] will be granted for **ALL** eyeglass lens options and upgrades not covered by the plan.	**N/A**
Lens Options and Upgrades: Thinner Lenses • Scratch Coating • U.V. Coating Anti-Reflective Coating • Transitions • Etc.		
Contact Lenses: (in lieu of eyeglasses)		
• The Contact Lens Benefit may be applied to **Contact Expenses**, including: Lenses and Professional Fitting / Follow-Up Care Fees • The Contact Lens Benefit is in addition to the Comprehensive Eye Exam.		
Elective / Cosmetic Contacts [1] (Disposable & Conventional Soft/Hard)	**$150.00** Retail Contact Lens Allowance (Member pays all Retail Contact Lens expenses over $150.00)	Reimbursed up to **$105.00**
Medically Necessary Contacts [1] *Contact Lenses Prescribed to treat specific Medical Conditions or Diseases of the eye*	100% Covered up to Approved U&C Amount, **$20.00 Co-Pay** *(Prior Approval is required to Authorize M.N. Contacts)*	Reimbursed up to **$210.00**

[1] You are eligible for contact lenses OR eyeglasses, **not both**, in any (12 month) Plan Year.

[2] If you choose to utilize Wal-Mart Vision Centers or Sam's Club Optical locations, please be advised that Wal-Mart's "Everyday Low Price" EDLP covered frame benefit level **differs** slightly from other providers in the network. Additionally, due to Wal-Mart's heavily discounted prices, there are no added preferred pricing discounts on non-covered upgrades, options or 2nd pair purchases at these locations. Please keep this in mind as you select a network provider.

Additional In-Network Discounts

• 20%[2] off an additional prescription Eyeglass or Sunglass (2nd pair) purchase.

DELTA DENTAL

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 0162-0001, 0003, 0004, 0005
New Paradigm for Education

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	50%	50%
Emergency Palliative Treatment – to temporarily relieve pain	100%	50%	50%
Sealants – to prevent decay of permanent teeth	100%	50%	50%
Brush Biopsy – to detect oral cancer	100%	50%	50%
Radiographs – X-rays	100%	50%	50%
Basic Services			
Minor Restorative Services – fillings and crown repair	75%	50%	50%
Endodontic Services – root canals	75%	50%	50%
Periodontic Services – to treat gum disease	75%	50%	50%
Oral Surgery Services – extractions and dental surgery	75%	50%	50%
Major Restorative Services – crowns	75%	50%	50%
Other Basic Services – misc. services	75%	50%	50%
Relines and Repairs – to bridges, implants, and dentures	75%	50%	50%
Major Services			
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Up to age 19	Up to age 19	Up to age 19

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.

EHIM
Pharmacy Benefits. *Managed.*

Your Rx Benefits

No Changes

Effective: 9/1/2015

We are pleased to announce that there will be NO changes to your existing pharmacy benefit plan for the upcoming year!

You can continue to utilize the current ID card that you have.

Summary of Copayments

Copayments are the dollar amount which will be collected at the pharmacy every time you receive a prescription. Generally, your copayment will be the lowest for generic prescriptions and highest for medications that are considered Non-Preferred under your plan design. Below highlights your plan's copay levels:

Customer Service

800-311-3446 • 24/7/365

EHIM's main mission is to provide our members with the best customer service possible. If you are experiencing a problem ***filling a retail or mail order prescription*** please contact EHIM's Pharmacy Help Desk. For your convenience, our help desk has a representative available ***24 hours a day, 7 days a week, 365 days a year.*** Our toll free number is 1-800-311-3446 and will be ***printed on the back of your ID card*** for easy reference.

EHIM values our clients and we appreciate the opportunity to continue to service our members.

$10.00 (20% if cost over $100)	Copayment on any generic medication
$40.00 (20% if cost over $150	Copayment on any Preferred Brand Medication
40%	Copayment on any Non-Preferred Brand Medication
$40.00 (20% if cost over $150)	Copayment on any Multi-Source Brand Medication (Brand Name Drugs that are dispensed when an exact generic is available) The *physician* will indicate "DAW" or "Dispense as Written" on the prescription.
$40.00 (20% if cost over $150)	Copayment **plus the difference** in cost between the brand & generic on any Multi-Source Brand Prescription (Brand Name Drugs that are dispensed when an exact generic is available) The *patient* indicates the brand to be dispensed.
Generic: 2x Brand: 3x NP Brand: 40%	Standard Copayment for all eligible maintenance medication filled in a three month supply. Brand & Generic eligible maintenance medications can be filled through the Local Retail Pharmacy in order to obtain them in a 3 month supply.

26711 Northwestern Highway, Suite 400 :: Southfield, MI 48033-2154
800-311-3446 :: 248-948-9900 :: www.ehimrx.com