Honey Creek Community School

October, 2013 Renewal

786752

Priority Health 100% HMO - Health Savings Account

Deductible: $3000 single / $6000 Family
Coinsurance: 100%
Coinsurance Maximum: $5000 single / $10,000 family (includes deductible and Rx copays)
Domestic Partner Rider included (same sex and opposite sex)

PCP Office Visit: Subject to deductible and coinsurance
Specialist Office Visit: Subject to deductible and coinsurance
Hospital / Surgical Care: Subject to deductible and coinsurance
Emergency Room: Subject to deductible and coinsurance
Urgent Care: Subject to deductible and coinsurance
Preventive Care: Covered 100%, no deductible

Prescription Drugs: Subject to deductible then $20 Generic / $60 Preferred Brand / $80 Non-Preferred Brand / 20% Preferred Specialty/ 20% Non-Preferred Specialty Rx Copay with Mail Order (2x) and Contraceptives. Maximum Specialty copayment of $200 preferred / $400 Non-Preferred per prescription after deductible.

		Current Rates	Renewal Rates	% Difference
Medical				
	Contracts			
Single	7	$250.25	$297.16	*18.75%*
Two Person	1	550.53	653.76	*18.75%*
Family	8	688.17	817.20	*18.75%*
Monthly Premium	16	7,807.64	9,271.48	*18.75%*
Monthly Difference			1,463.84	
Annual Premium		$93,691.68	$111,257.76	
Annual Difference			17,566.08	*18.75%*

A.M. Best Rating: A- (Excellent)

KAPNICK INSURANCE GROUP

		Current Rates		Renewal Rates
		HMO		HMO
		HSA 100-2		HSA 100-2
Hospital Coverage		100% Coinsurance		100% Coinsurance
Office Visit Copay		0%		0%
Medical Deductible		$3,000/$6,000		$3,000/$6,000
Rx Copay		$20/$60/$80 20%/20%		$20/$60/$80 20%/20%
Contraceptives		Covered		Non Exempt
Rx Deductible		Combined Rx/Med		Combined Rx/Med
OOP Individual/Family		$5,000 / $10,000		$5,000 / $10,000
Emergency Room Copay		0%		0%
Ambulance Copay		0%		0%
Domestic Partner		Same & Opposite Gender		Same & Opposite Gender
Health Care Reform Status		Non-Grandfathered		Non-Grandfathered
Coverage Rates*	#			
Michigan Employees				
Single	7	$250.25		$297.16
Double	1	$550.53		$653.76
Family	8	$688.17		$817.20
Monthly Premium*		$7,807.64		$9,271.48
Yearly Premium*		$93,691.68		$111,257.76
Percent Change				18.75 %

*NOTE: Please note rates, fees, and/or claims projections do not include the "Michigan claims tax" effective January 1, 2012, or similar fees or taxes that may be imposed by the Federal Government or the State of Michigan. Rates and fees will be adjusted as necessary to incorporate such assessments or taxes and will be communicated to you as soon as they are known. Priority Health participation rules apply; see Priority Health New Group Application. Priority Health is not liable for agent or employer group errors. For New groups, final rates will be based on final enrollment. Rates guaranteed for 12 months from the effective date of coverage. For renewing groups, rates are not valid until verification of all pre-renewal documents has been completed. Benefits and generated rates may be pending and subject to final approval by the Michigan Office of Financial and Insurance Regulation. In general Mental Health Parity does not apply for small businesses. The rates produced are not valid when a group is required to comply with Mental Health Parity. Please contact the Small Business department for assistance.

PriorityHealth
priorityhealth.com
Priority HMO HSA 100-2
Summary of Benefits
HONEY CREEK COMMUNITY SCHOOL
10/01/2012 – 09/30/2013

The following information is provided as a summary of benefits available under your Priority Health plan. This summary is not a substitute for your Certificate of Coverage and Schedule of Copayments and Deductibles. **It is not a binding contract. Limitations and exclusions apply to benefits listed below.** Coverage for services is based on Medical / Clinical necessity as determined by Priority Health's Medical Department. A complete listing of covered services, limitations and exclusions is contained in the Certificate of Coverage, Schedule of Copayments and Deductibles and any applicable riders issued to you. You may request a copy of the from Priority Health's Customer Service Department at 616 942-1221 or 800 446-5674 or on our web site priorityhealth.com. Contact Priority Health's Customer Service Department if you have questions about your benefits or coverage.

Copayment = Member pays
% Coverage = Priority Health pays

Deductible	
Individual Deductible per Contract Year	$3,000
Family Deductible per Contract Year	$6,000

Note: The Deductible is the amount of Covered Expenses you must incur during the Contract Year before benefits will be paid. The Deductible is applicable to all covered services except:

- Routine Maternity Care (the Deductible does apply to facility charges for delivery)
- Preventive health care services

Individual & Family Contract Deductibles: If you are the only individual on your contract, you have an Individual Contract and the Individual Contract Deductible applies. If you have more than one individual on your contract, you have a Family Contract and only the Family Contract Deductible Applies. The Family Contract Deductible can be satisfied by any one family member or by any combination of family members. Deductible amounts you pay are included in your out-of-pocket maximum. Your Deductible renews each Contract Year.

Maximums	
Individual Out-of-Pocket Maximum per Contract Year	$5,000
Family Out-of-Pocket Maximum per Contract Year	$10,000

Note: Out-of-Pocket maximum is the amount of covered expenses that you and/or your covered dependents will pay.

If you have an Individual Contract, when calculating your Out-of-Pocket Maximum, we will include all Copayments and Deductibles you paid toward medical Covered Services during a Contract Year. If you have a Family Contract, we will include all Copayments and Deductibles you and your family paid collectively toward medical Covered Services during a Contract Year.

Once the applicable Out-of-Pocket Maximum is met, all further medical Covered Services for that Contract Year will be paid by Priority Health at 100% without requirement of Copayment.

Your Out-of-Pocket Maximum limit renews each Contract Year.

Benefits	
Preventive Health Care Services	
A summary of Covered Preventive Health Care Services is contained in your Certificate of Coverage. Priority Health's complete preventive health care guidelines are available in	Services Covered in Full. Deductible does not apply.

Benefits	
the Member Center on priorityhealth.com, or you may request a copy from our Customer Service department.	
Physician Services	
Primary Care Provider (PCP) Office Visits	100% Coverage. Deductible applies.
Specialist Office Visits Referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary	100% Coverage. Deductible applies.
Routine Pre and Postnatal Care	Services Covered in Full. Deductible only applies to facility and anesthesia charges.
Allergy Care	100% Coverage. Deductible applies.
Outpatient Services	
Diagnostic Laboratory and X-Ray	100% Coverage. Deductible applies.
Chemotherapy	100% Coverage. Deductible applies.
Radiation Therapy	100% Coverage. Deductible applies.
Hemodialysis	100% Coverage. Deductible applies.
Advanced Diagnostic Imaging Includes, but is not limited to the following: CT, CTA, MRI, MRA, Nuclear Cardiology Studies and PET scanning	100% Coverage. Deductible applies.
Rehabilitative Medicine Services	
Physical & Occupational Therapy Includes Spinal Manipulation	100% Coverage with a limitation of 30 visits per Contract Year (combined benefit for all therapies listed). Deductible applies.
Speech Therapy	100% Coverage with a limitation of 30 visits per Contract Year. Deductible applies.
Cardiac and Pulmonary Rehabilitation	100% Coverage with a limitation of 30 visits per Contract Year (combined benefit for all therapies listed). Deductible applies.
Hospital Services	
Inpatient Services Semi-private room and intensive care, surgery and all related surgical services, ancillary services while inpatient **Note:** Non-emergency inpatient hospital admissions, other than for normal labor and delivery, must be approved in advance by Priority Health.	100% Coverage. Deductible applies.
Inpatient Hospital Professional Services	100% Coverage. Deductible applies.
Outpatient Surgery at Hospital or Ambulatory Center Surgery and all related surgical services	100% Coverage. Deductible applies. Prior approval is required for certain radiology examinations.
Outpatient Hospital Professional Services	100% Coverage. Deductible applies.
Certain Surgeries and Treatments (physician fees only)	
Bariatric Surgery – limit once per lifetime **Reconstructive Surgery** – breast reduction, blepharoplasty of upper lids, rhinoplasty, panniculectomy,	Physician fees are Covered at 50% of the first $2,000 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies.

Benefits	
septorhinoplasty, and surgical treatment of male gynecomastia **Skin Disorder Treatments** – scar revisions, keloid scar treatment, treatment of hyperhidrosis, excision of lipomas, excision of seborrheic keratoses, excision of skin tags, treatment of vitiligo, port wine stains, and hemangioma treatment **Varicose Veins Treatments** **Sleep Apnea Treatment Procedures**	Deductible applies. Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime unless Medically/Clinically Necessary to correct or reverse complications from a previous bariatric procedure.
Emergency Medical Care (in or out of the service area)	
Hospital Emergency Room	100% Coverage. Deductible applies.
Urgent Care Center	100% Coverage. Deductible applies.
Physician's Office	100% Coverage. Deductible applies.
Ambulance (land or air)	100% Coverage. Deductible applies.
Family Planning / Infertility Services	
Vasectomy	100% Coverage for physician services. Deductible applies. Coverage limited only to when performed in physician's office or when in connection with other Covered inpatient or outpatient surgery. 100% Coverage for outpatient and inpatient facility charges. Deductible applies. Coverage limited only to when performed in connection with other Covered inpatient or outpatient surgery.
Tubal Ligation	
Professional Fees	100% Coverage. Deductible applies.
Outpatient	100% Coverage. Deductible applies.
Inpatient	100% Coverage only when performed in connection with delivery or other covered inpatient surgery. Deductible applies.
Consultations, pre-operative and post-operative visits	100% Coverage. Deductible applies.
Infertility Services Counseling and treatment of underlying cause of infertility	50% Coverage. Deductible applies.
Mental Health / Substance Abuse Services **Note:** All Mental Health and Substance Abuse services must be approved in advance by our Behavioral Health Department 616 464-8500 or 800 673-8043. Treatment may be covered as deemed clinically necessary by our Behavioral Health Department.	
Inpatient Mental Health Services	100% Coverage. Deductible applies. Maximum 20 days per Contract Year.
Outpatient Mental Health Services	100% Coverage with limitations of 20 visits per Contract Year. Deductible applies. (Two group therapy visits count as one outpatient visit.)
Substance Abuse Services (including sub-acute, intermediate care and outpatient evaluation/therapy) **Note:** Day/visit limits may be extended in order to comply with the combined minimum annual benefit for substance abuse services per Contract Year as determined by the	80% Coverage up to a maximum of 10 days per Contract Year for inpatient detoxification/rehabilitation and partial hospitalization. Prior Approval required. Deductible applies. 80% Coverage up to a maximum of 30 outpatient visits per Contract Year for intensive outpatient care (usually three to

Benefits	
State of Michigan.	four hours daily), outpatient evaluation, individual therapy and group therapy. Two group therapy visits count as one visit. Deductible applies.
Other Services	
Temporomandibular Joint Dysfunction or Syndrome (TMJS)	50% Coverage. Deductible applies.
Orthognathic Surgery	50%Coverage. Deductible applies. Prior approval required.
Prosthetics & Orthotics	50% Coverage. Deductible applies. Prior approval required for equipment over $1,000.
Durable Medical Equipment	50% Coverage. Deductible applies. Prior approval required for equipment over $1,000.
Skilled Nursing, Sub-acute, Inpatient Rehabilitation, and Hospice Facility	100% Coverage. Deductible applies. Maximum 45 days per Contract Year (combined benefit for all services).
Home Health Care	100% Coverage. Deductible applies. For rehabilitative therapy provided in the home, refer to Rehabilitative Medicine services for Copayment information. Prior approval required.
Additional Benefits	
Pharmacy Services	
Prescription Drugs **Note:** Prescription drug coverage is based on the usage of a medication formulary.	Covered with a $20 Generic/$60 Preferred Brand/$80 Non-Preferred Brand/20% Preferred Specialty/20% Non-Preferred Specialty Copayment per prescription after deductible. Includes contraceptive medications and contraceptive devices. Infertility drugs covered with a 50% Copayment. (Limitations apply). Maximum Specialty Copayment of $200 Preferred/ $400 Non-Preferred per prescription.
Prescription Mail Order	Prescription drugs filled for up to 90 days with a $40 Generic/$120 Preferred Brand/$160 Non-Preferred Brand/20% Preferred Specialty/20% Non-Preferred Specialty Copayment per prescription after deductible.
Eligibility Information	
Dependent Children	Covered until dependent turns age 26.
DEPENDENT COVERAGE REQUIRED NOTICE Individuals whose coverage ended or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26, are eligible to enroll in this plan. Individuals may enroll during the group's next open enrollment period or within 30 days after the group's next renewal.	

Due to recent healthcare reform legislation, certain women's preventive health benefits may be available to you. These benefits have not yet been updated in this summary. Contact customer service if you have questions about Preventive Health benefits.

Affidavit for domestic partner benefits

PriorityHealth

For same or opposite gender partners

Eligibility

You may enroll as a Covered Dependent if you are the Domestic Partner of the Subscriber, as defined by and under conditions allowed by the employer. A Domestic Partner is an individual who lives with the Subscriber in a Domestic Partnership. A Domestic Partnership is defined as:

- Two individuals of the same or opposite gender who live together in a long-term relationship of indefinite duration with an exclusive mutual commitment similar to that of marriage;
- A relationship in which the partners have agreed to be responsible for each other's welfare; and
- The partners are financially interdependent.
- Additionally, the subscriber must comply with the eligibility requirements that are required by the group and outlined in the agreement between the Group and Priority Health.

Enrollment

SECTION 4 of your Group's Certificate, "ENROLLMENT" defines when a Domestic Partner is eligible to enroll for coverage. Section 4.B(1) "Special Enrollment of Newly Eligible Employees and Dependents" is amended by adding the following language to the end of the first paragraph: Domestic Partners of eligible employees are not eligible to enroll under this Section 4.B(1).

"Continuation, Conversion OR Extension of Benefits" does not apply to Domestic Partners. The only persons eligible for COBRA coverage are the spouse and the dependent children of a Subscriber. Domestic Partners are not eligible for COBRA coverage. Domestic Partners are entitled to conversion coverage as described in Section 13.B.

Dependents of the Subscriber and/or the Subscriber's Domestic Partner, who are financially dependent upon the Domestic Partner, are eligible for coverage subject to all of the terms and conditions of the Certificate, this rider and any other riders attached to this Certificate.

We, _____ and _____, have read and understand the above, we affirm all of the following:

1. We are the sole, same-sex or opposite sex domestic partners of the other;
2. We are 18 years of age or older;
3. Neither of us legally married;
4. We are not related by blood in manner that would bar legal marriage if we were not of the same or opposite gender;
5. We have lived together at the same regular and permanent residence for a minimum of 6 consecutive months and submit this affidavit as proof. We agree to provide the group and/or Priority Health additional written proof that we meet this residency requirement, if required to do so, and understand that a failure to provide such proof could result in loss of coverage;
6. We are financially interdependent;
7. If, at any time, we terminate our domestic partnership or if any of the above statements cease to be true, we agree to notify our employer and Priority Health with 30 days of termination;
8. We understand that we may not file another affidavit for domestic partnership benefits for at least 12 months after termination of this domestic partnership; and
9. We agree to reimburse the employer and Priority Health for cost of providing benefits if the domestic partner is not eligible under the employer's definitions.

Date: _____

Employee Signature

Subscribed and sworn to before me this _____ day of _____ , 20

Notary Public, _____ County in Michigan

My Commission Expires: _____

Domestic Partner Signature _____

Subscribed and sworn to before me this ____day of _____ , 20_____

Notary Public, _____ County in Michigan

My Commission Expires: _____

Affidavit for domestic partner benefits

PriorityHealth

For same gender partners

Eligibility

You may enroll as a Covered Dependent if you are the Domestic Partner of the Subscriber, as defined by and under conditions allowed by the employer. A Domestic Partner is an individual who lives with the Subscriber in a Domestic Partnership. A Domestic Partnership is defined as:

- Two individuals of the same gender who live together in a long-term relationship of indefinite duration with an exclusive mutual commitment similar to that of marriage;
- A relationship in which the partners have agreed to be responsible for each other's welfare; and
- The partners are financially interdependent.
- Additionally, the subscriber must comply with the eligibility requirements that are required by the group and outlined in the agreement between the Group and Priority Health.

Enrollment

SECTION 4 of your Group's Certificate, "ENROLLMENT" defines when a Domestic Partner is eligible to enroll for coverage. Section 4.B(1) "Special Enrollment of Newly Eligible Employees and Dependents" is amended by adding the following language to the end of the first paragraph: Domestic Partners of eligible employees are not eligible to enroll under this Section 4.B(1).

"Continuation, Conversion OR Extension of Benefits" does not apply to Domestic Partners. The only persons eligible for COBRA coverage are the spouse and the dependent children of a Subscriber. Domestic Partners are not eligible for COBRA coverage. Domestic Partners are entitled to conversion coverage as described in Section 13.B.

Dependents of the Subscriber and/or the Subscriber's Domestic Partner, who are financially dependent upon the Domestic Partner, are eligible for coverage subject to all of the terms and conditions of the Certificate, this rider and any other riders attached to this Certificate.

We, _____ and _____, have read and understand the above, we affirm all of the following:

1. We are the sole, same-sex domestic partners of the other;
2. We are 18 years of age or older;
3. Neither of us legally married;
4. We are not related by blood in manner that would bar legal marriage if we were not of the same or opposite gender;
5. We have lived together at the same regular and permanent residence for a minimum of 6 consecutive months and submit this affidavit as proof. We agree to provide the group and/or Priority Health additional written proof that we meet this residency requirement, if required to do so, and understand that a failure to provide such proof could result in loss of coverage;
6. We are financially interdependent;
7. If, at any time, we terminate our domestic partnership or if any of the above statements cease to be true, we agree to notify our employer and Priority Health with 30 days of termination;
8. We understand that we may not file another affidavit for domestic partnership benefits for at least 12 months after termination of this domestic partnership; and
9. We agree to reimburse the employer and Priority Health for cost of providing benefits if the domestic partner is not eligible under the employer's definitions.

Date: _____

Employee Signature

Subscribed and sworn to before me this _____ day of _____ , 20

Notary Public, _____ County in Michigan

My Commission Expires: _____

Domestic Partner Signature _____

Subscribed and sworn to before me this ____day of _____ , 20_____

Notary Public, _____ County in Michigan

My Commission Expires: _____

PriorityHealth

Small Group Minimum Participation Rules

Priority Health and Priority Health Insurance Company (collectively, "Priority Health")
Effective January 1, 2012

Overall participation requirement for groups of the following sizes:

- 2-10 eligible employees*: 100% of eligible employees seeking coverage must participate.
- 11-25 eligible employees*: 75% of eligible employees seeking coverage must participate.
- 26-50 eligible employees*: 50% of eligible employees seeking coverage must participate.

Participation requirements for multiple Priority Health plan offerings:

- Groups with 2-10 eligible employees* enrolling with Priority Health may offer 1 plan design.
- Groups with 11-50 eligible employees* enrolling with Priority Health may offer 2 plan designs.
    - When multiple plans are offered, the overall participation requirements apply to each plan. Priority Health may elect to waive this rule for groups of 11-50 eligible employees* if the two Priority Health plans together enroll 100% of employees seeking coverage (e.g. 40% enroll in Plan A and 60% enroll in Plan B).
    - A minimum of five (5) enrolled contracts in each plan including an HSA, if offered.
    - HealthbyChoice℠ plans may only be paired with another HealthbyChoice plan.
    - Existing groups may maintain their current plan offerings and participation requirements if no benefit changes are made. If any plan changed in any way or if a plan is added, groups are required to change to the new plan options available on their renewal effective date.

Participation of active employees:

- Up to 20% of subscribers may be retired. Retiree/Early Retiree coverage is not available to new groups.
- Sponsored Dependent coverage is not available to new groups, however, eligible dependents may qualify for MyPriority℠ individual and family plans. Existing groups with sponsored dependents currently enrolled may continue to enroll additional eligible sponsored dependents.
- Up to 20% of subscribers may be covered as Surviving Spouses. Surviving Spouse coverage is not available to new groups, however, subscribers may qualify for other MyPriority individual and family plans or Individual Medicare products. Groups with surviving spouses currently enrolled may enroll additional surviving spouses.

Participation of employees outside the Service Area/Michigan:

- HMO – 100% of enrolled employees must live or work in the service area.
- POS – 90% of enrolled employees must live and work in the service area.
- PPO – 70% enrolled employees must live in Michigan.

*"Eligible employees" includes all employees who work on a full-time basis for 30 or more hours a week as well as employees who work 17.5 to 30 hours a week if elected by the group in the Group Agreement.

Participation rules applied to segments:
If Priority Health is offered to a segment of employees (such as those who live in the service area or management or administrative employees), participation rules for the segment covered by Priority Health plan will apply as if the segment offered by Priority Health is the entire group (e.g. in a group of 45 employees, 30 of whom live outside the service area and are not covered by Priority Health, the participation rules for a group of 15 employees will apply). If the entire group is comprised of more than 50 employees, the group will be considered a large group and, therefore, not subject to these small group participation rules.

Other Requirements for Small Groups:

1. The group must be of a permanent nature and financially stable.

2. The group must have been formed for a purpose other than to secure group insurance.

3. Seasonal employees (those working less than 36 weeks per year) and 1099 contractors are not eligible.

4. Directors, corporate officers, trustees, corporate lawyers, elected officials, and owners or partners are not eligible unless they are full-time employees.

5. The group must carry Worker's Compensation coverage unless not required by law.

6. Priority Health will not allow a plan to co-exist with an employer-sponsored individual plan if doing so violates Priority Health participation rules.

7. The group's extension of coverage policy for lay-off or disability may not exceed 6 months. If a group has no written policy for laid-off employees, the group's standard termination rule of date of termination or end of month applies. If a group has no written policy for employees on a disability leave, the term of coverage shall not exceed 6 months from the date of disability.

8. Employer contribution requirements: The employer must contribute 50% of the single rate or no less than 40% of the single, double and family rate. This requirement includes early retirees, retirees and surviving spouses, if applicable.