Alliance Health and Life Insurance Company (Alliance)
Preferred Provider Organization (PPO)
Summary of Benefits
HAP PPO 1400-0 HSA A / Rx 4H **PPO**
PPS00247

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,400 Self Only; $2,800 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$2,800 Self Only; $5,600 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	Deductible does not include copays or coinsurance. In and Out-of-Network deductibles accumulate separately. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	20%	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$2,800 Self Only; $5,600 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$5,600 Self Only; $11,200 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	These values do not accumulate: premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified. In and Out-of-Network Out-of-Pocket Maximums accumulate separately.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	Not Covered	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	Not Covered	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	Not Covered	
Immunizations	Covered - Deductible does not apply	Not Covered	
Outpatient & Physician Services			
Primary Care Office Visit	Covered after deductible	20% Coinsurance after deductible	
Telehealth Visit	Covered after deductible	Not Covered	Through our contracted telehealth services provider.
Specialist Office Visit	Covered after deductible	20% Coinsurance after deductible	
Routine Audiology Exam	Covered - Deductible does not apply	Not Covered	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	Not Covered	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Chiropractic Services	Covered after deductible	20% Coinsurance after deductible	Manipulation of the spine for subluxation only; Up to 20 visits per benefit period (Combined In and Out-of-Network).
Allergy Treatment	Covered after deductible	20% Coinsurance after deductible	
Allergy Injections	Covered after deductible	20% Coinsurance after deductible	
Laboratory & Pathology	Covered after deductible	20% Coinsurance after deductible	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after deductible	20% Coinsurance after deductible	Services require preauthorization.
Radiology (X-ray)	Covered after deductible	20% Coinsurance after deductible	Some services require preauthorization.
Radiation Therapy & Chemotherapy	Covered after deductible	20% Coinsurance after deductible	
Dialysis	Covered after deductible	20% Coinsurance after deductible	Out-of-Network benefits are not covered unless Prior Authorized.
Outpatient Medical Drugs	Covered after deductible	20% Coinsurance after deductible	
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	20% Coinsurance after deductible	
Ambulatory Surgical Center	Covered after deductible	20% Coinsurance after deductible	
Professional Surgical and Related Services	Covered after deductible	20% Coinsurance after deductible	
Emergency/Urgent Care			
Urgent Care	Covered after In-Network Deductible		
Emergency Room Care	Covered after In-Network Deductible		
Emergency Medical Transportation	Covered after In-Network Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	Covered after deductible	20% Coinsurance after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	20% Coinsurance after deductible	
Bariatric Surgery and Related Services	Covered after deductible	Not Covered	One procedure per lifetime

Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	Not Covered	Covered under Preventive Services
Postnatal Office Visits	Covered after deductible	20% Coinsurance after deductible	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	See Inpatient Hospital Services	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	See Inpatient Hospital Services	
Outpatient Services	Covered after deductible	20% Coinsurance after deductible	
Other Services			
Home Health Care	Covered after deductible	20% Coinsurance after deductible	Does not include Rehabilitation Services; Up to 100 visits per benefit period (Combined In and Out-of-Network).
Hospice Care	Covered after deductible	20% Coinsurance after deductible	Unlimited.
Skilled Nursing Care	Covered after deductible	20% Coinsurance after deductible	Up to 100 days per benefit period (Combined In and Out-of-Network).
Durable Medical Equipment; Prosthetics & Orthotics	Covered after deductible	20% Coinsurance after deductible	Covered for approved equipment only.
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids after deductible $689 Copay per Hearing Aid for Basic Technology Hearing Aids after deductible $989 Copay per Hearing Aid for Prime Technology Hearing Aids after deductible $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids after deductible $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids after deductible	Not Covered	Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.
Vision Hardware	Covered - Deductible does not apply	Not Covered	Covered once each 12-consecutive month period. Limited to Collection Frames or Collection Contact Lenses.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	20% Coinsurance after deductible	May be rendered at home; Up to 60 combined visits per benefit period (Combined In-Network and Out-of-Network).
Habilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	Not Covered	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	Covered after deductible	Not Covered	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	See Outpatient Surgical Services	Limited to vasectomy
Infertility Services	Covered after deductible	20% Coinsurance after deductible	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	Covered after deductible	20% Coinsurance after deductible	One attempt per lifetime
Temporomandibular Joint Disorder	Covered after deductible	20% Coinsurance after deductible	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply after deductible		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Non-Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply after deductible		
Preferred Brand Drugs	$40 Copay 30 day supply, $80 Copay 90 day supply after deductible		
Non-Preferred Brand Drugs	$80 Copay 30 day supply, $160 Copay 90 day supply after deductible		
Preferred Specialty Drugs	$80 Copay 30 day supply at specialty pharmacy only after deductible		
Non-Preferred Specialty Drugs	$80 Copay 30 day supply at specialty pharmacy only after deductible		

- In case of conflict between this summary and your PPO Group Health Insurance Policy and Riders, the terms and conditions of the PPO Group Health Insurance Policy and Riders will govern. This plan includes a network of health care providers through which services are covered at the In-Network level of benefits. If you receive covered services from a provider that is not part of the plan's network, they will be processed at the lower Out-of-Network benefit level.
- Elective hospital admissions require that Alliance be notified prior to the admission. Alliance must be notified within 48 hours after any emergency hospital admission. Failure to notify Alliance could result in a reduction or denial of benefits.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result In a reduction or denial of benefits.
- PPO plans are offered through Alliance health and Life Insurance Company, a wholly owned subsidiary of health Alliance Plan.

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT
GROUP ID: PROSPECT

October 5, 2020
OPP-8096 | JT

PREMIUM RATE NOTIFICATION
HAP PPO PROSPECT OPTIONS

Renewal Date: January 1
Monthly Premium Rates Effective: January 1, 2021 through December 31, 2021

Rates **EXCLUDE** Taxes/Fees*

Contract Type	Contracts	HAP PPO 1400-0 HSA A / Rx 4H	HAP PPO SBP HSA 1400-0 / Rx HSA SBP
Subscriber Only	69	$ 574.09	$ 579.81
Subscriber & Spouse	46	$ 1,377.82	$ 1,391.54
Subscriber & Child	0	$ 1,377.82	$ 1,391.54
Subscriber & Children	0	$ 1,722.27	$ 1,739.43
Subscriber, Spouse & Child(ren)	96	$ 1,722.27	$ 1,739.43
Estimated Monthly Premium w/out Taxes/Fees		$ 268,329.85	$ 271,003.01
Check Plan Selection →			

Rates **INCLUDE** Taxes/Fees*

Contract Type	Contracts	HAP PPO 1400-0 HSA A / Rx 4H	HAP PPO SBP HSA 1400-0 / Rx HSA SBP
Subscriber Only	69	$ 576.49	$ 582.21
Subscriber & Spouse	46	$ 1,383.58	$ 1,397.30
Subscriber & Child	0	$ 1,383.58	$ 1,397.30
Subscriber & Children	0	$ 1,729.47	$ 1,746.63
Subscriber, Spouse & Child(ren)	96	$ 1,729.47	$ 1,746.63
Estimated Monthly Premium with Taxes/Fees		$ 269,451.61	$ 272,124.77
Check Plan Selection →			

*** IMPORTANT: Please see Premium Rate Conditions on Page 3**

Please sign and return to your HAP Account Executive
Tom Heidger | theidger@hap.org | (810) 230-2282
As the Executive Representative of the group listed above, my signature acknowledges the Premium Rates, Effective Dates, Plans and Premium Rate Conditions as outlined on this Rate Notification as well as the Terms and Conditions of my HAP Group Operating Agreement.

I also acknowledge
Premium rates include commission per HAP's Standard Commission Schedule
Agency Name: Walton Agency, Inc.

Authorized Signature _____

Printed Name _____

Title _____

Company _____

Date _____

We at Health Alliance Plan look forward to our continued partnership and appreciate your business.

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT
GROUP ID: PROSPECT

October 5, 2020
OPP-8096 | JT

PREMIUM RATE NOTIFICATION
HAP PPO PROSPECT OPTIONS

Renewal Date: January 1
Monthly Premium Rates Effective: January 1, 2021 through December 31, 2021

Plan Name*	**HAP PPO 1400-0 HSA A / Rx 4H**	**HAP PPO SBP HSA 1400-0 / Rx HSA SBP**
Medical Product ID	**HAP PPO 1400-0 HSA A / Rx 4H**	**HAP PPO SBP HSA 1400-0 / Rx HSA SBP**
Rx Product ID		
INN Deductible	$1,400	$1,400
INN Coinsurance	0%	0%
INN Coinsurance Maximum	N/A	N/A
INN Out-of-Pocket Maximum	$2,800	$2,350
OON Deductible	$2,800	$2,800
OON Coinsurance	20%	20%
OON Coinsurance Maximum	N/A	N/A
OON Out-of Pocket Maximum	$5,600	$4,700
Inpatient	Ded/Coins	Ded/Coins
OP Hospital	Ded/Coins	Ded/Coins
Emergency Room	Ded/Coins	Ded/Coins
Urgent Care	Ded/Coins	Ded/Coins
PCP	Ded/Coins	Ded/Coins
Telemedicine	Ded/Coins	Ded/Coins
SCP	Ded/Coins	Ded/Coins
Preferred Generic	Ded then $10 Copay	Ded then $10 Copay
Non-Preferred Generic	Ded then $10 Copay	Ded then $10 Copay
Preferred Brand	Ded then $40 Copay	Ded then $20 Copay
Non-Preferred Brand	Ded then $80 Copay	Ded then $40 Copay
Preferred Specialty	Ded then $80 Copay	Ded then $40 Copay
Non-Preferred Specialty	Ded then $80 Copay	Ded then $40 Copay

*** IMPORTANT: Please refer to your Benefit Summary and/or SBC for more detailed benefit information**

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT **October 5, 2020**
GROUP ID: PROSPECT **OPP-8096 | JT**

PREMIUM RATE NOTIFICATION
HAP PPO PROSPECT OPTIONS

Renewal Date: January 1
Premium Rate Conditions Effective: January 1, 2021 through December 31, 2021

Premium Rate Conditions
PROSPECT; Premium rates are based upon the census enrollment.

Health Alliance Plan is regulated by the Department of Insurance and Financial Services (DIFS). Premium rates are conditional and subject to change based on the annual rate filing and its approval with DIFS.

Premium rates are contingent upon an employer group meeting the minimum contribution of 50% or more of the single premium.

Health Alliance Plan/Alliance Health & Life reserves the right to re-rate an employer group if the enrollment and other demographic factors of the group changes by more than 10%. This applies to not only shifts within the group's fully insured population, but also shifts in funding mechanism – for example, a fully insured group electing self-funded for a portion of their population. Final rates, taxes, and fees will be based on actual enrollment.

Illustrative premiums have been provided for informational purposes which include applicable taxes based upon current tax assessments and were developed at a fixed point in time. The actual taxes on your monthly invoice may fluctuate due to shifts in membership. In addition, pending regulatory decisions may affect the taxes applied.

Benefit descriptions are informational only. If there is a conflict between the coverage description in this report and the Summary of Benefits and Coverage or Schedule of Benefits, the terms of the Summary of Benefits and Coverage or Schedule of Benefits shall control.

Contact your HAP Account Executive for HRA or HSA information and fees.

Monthly remittance reports and payment should only be sent to the following address:
DEPARTMENT #270301 * HEALTH ALLIANCE PLAN * P.O. BOX 67000 * DETROIT, MI 48267-2703

Prepared by Underwriting Analyst: Janice Trinklein

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits
HAP HMO 3000-20 A / Rx 5 **HMO**
AAS00156

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$3,000 Individual; $6,000 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	20%	N/A	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$5,000 Individual; $10,000 Family	N/A	These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$20 Copay - Deductible does not apply	N/A	
Telehealth Visit	$10 Copay - Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$40 Copay - Deductible does not apply	N/A	
Routine Audiology Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Chiropractic Services	$40 Copay - Deductible does not apply	N/A	Manipulation of the spine for subluxation only; Up to 20 visits per benefit period.
Allergy Treatment	20% Coinsurance after deductible	N/A	
Allergy Injections	20% Coinsurance after deductible	N/A	
Laboratory & Pathology	20% Coinsurance after deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	20% Coinsurance after deductible	N/A	Services require preauthorization.
Radiology (X-ray)	20% Coinsurance after deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	20% Coinsurance after deductible	N/A	
Dialysis	20% Coinsurance after deductible	N/A	
Outpatient Medical Drugs	20% Coinsurance after deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	20% Coinsurance after deductible	N/A	
Ambulatory Surgical Center	20% Coinsurance after deductible	N/A	
Professional Surgical and Related Services	20% Coinsurance after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$75 Copay - Deductible does not apply		
Emergency Room Care	$250 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	20% Coinsurance after deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	20% Coinsurance after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	20% Coinsurance after deductible	N/A	
Bariatric Surgery and Related Services	20% Coinsurance after deductible	N/A	One procedure per lifetime

Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services
Postnatal Office Visits	$40 Copay - Deductible does not apply	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$20 Copay - Deductible does not apply	N/A	
Other Services			
Home Health Care	20% Coinsurance after deductible	N/A	Does not include Rehabilitation Services; Up to 100 visits per benefit period.
Hospice Care	20% Coinsurance after deductible	N/A	Unlimited.
Skilled Nursing Care	20% Coinsurance after deductible	N/A	Covered for authorized services; Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	20% Coinsurance after deductible	N/A	Covered for approved equipment only.
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids - Deductible does not apply $689 Copay per Hearing Aid for Basic Technology Hearing Aids - Deductible does not apply $989 Copay per Hearing Aid for Prime Technology Hearing Aids - Deductible does not apply $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids - Deductible does not apply $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids - Deductible does not apply	N/A	Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.
Vision Hardware	Covered - Deductible does not apply	N/A	Covered once each 12-consecutive month period. Limited to Collection Frames or Collection Contact Lenses.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$40 Copay - Deductible does not apply	N/A	May be rendered at home; Up to 60 combined visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	$40 Copay - Deductible does not apply	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	$20 Copay - Deductible does not apply	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy.
Infertility Services	20% Coinsurance after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	20% Coinsurance after deductible	N/A	One attempt per lifetime.
Temporomandibular Joint Disorder	20% Coinsurance after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Non-Preferred Generic Drugs	$20 Copay 30 day supply, $40 Copay 90 day supply		
Preferred Brand Drugs	$40 Copay 30 day supply, $80 Copay 90 day supply		
Non-Preferred Brand Drugs	$80 Copay 30 day supply, $160 Copay 90 day supply		
Preferred Specialty Drugs	30% Coinsurance ($200 max) 30 day supply at Specialty pharmacy only		
Non-Preferred Specialty Drugs	50% Coinsurance ($200 max) 30 day supply at Specialty pharmacy only		

Template Rev 01/2020

- In case of conflict between this summary and your HMO Subscriber Contract and Riders, the terms and conditions of the HMO Subscriber Contract and Riders will govern.
- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours after any emergency hospital admission. Failure to notify HAP could result in a reduction or denial of benefits.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.
- Students away at school are covered for acute illness and injury related services according to HAP criteria.

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT
GROUP ID: PROSPECT

October 5, 2020
OPP-8096 | JT

PREMIUM RATE NOTIFICATION
HAP HMO PROSPECT OPTIONS

Renewal Date: January 1
Monthly Premium Rates Effective: January 1, 2021 through December 31, 2021

Rates **EXCLUDE** Taxes/Fees*

Contract Type	Contracts	HAP HMO 3000-20 A / Rx 5
Subscriber Only	69	$ 476.47
Subscriber & Spouse	46	$ 1,143.53
Subscriber & Child	0	$ 1,143.53
Subscriber & Children	0	$ 1,429.41
Subscriber, Spouse & Child(ren)	96	$ 1,429.41

Estimated Monthly Premium w/out Taxes/Fees $ 222,702.17

Check Plan Selection →

Rates **INCLUDE** Taxes/Fees*

Contract Type	Contracts	HAP HMO 3000-20 A / Rx 5
Subscriber Only	69	$ 478.87
Subscriber & Spouse	46	$ 1,149.29
Subscriber & Child	0	$ 1,149.29
Subscriber & Children	0	$ 1,436.61
Subscriber, Spouse & Child(ren)	96	$ 1,436.61

Estimated Monthly Premium with Taxes/Fees $ 223,823.93

Check Plan Selection →

*** IMPORTANT: Please see Premium Rate Conditions on Page 3**

Please sign and return to your HAP Account Executive
Tom Heidger | theidger@hap.org | (810) 230-2282
As the Executive Representative of the group listed above, my signature acknowledges the Premium Rates, Effective Dates, Plans and Premium Rate Conditions as outlined on this Rate Notification as well as the Terms and Conditions of my HAP Group Operating Agreement.

I also acknowledge
Premium rates include commission per HAP's Standard Commission Schedule
Agency Name: Walton Agency, Inc.

Authorized Signature _____

Printed Name _____

Title _____

Company _____

Date _____

We at Health Alliance Plan look forward to our continued partnership and appreciate your business.

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT
GROUP ID: PROSPECT

October 5, 2020
OPP-8096 | JT

PREMIUM RATE NOTIFICATION
HAP HMO PROSPECT OPTIONS

Renewal Date: January 1
Premium Rate Conditions Effective: January 1, 2021 through December 31, 2021

Plan Name*	**HAP HMO 3000-20 A / Rx 5**
Medical Product ID	**HAP HMO 3000-20 A / Rx 5**
Rx Product ID	
INN Deductible	$3,000
INN Coinsurance	20%
INN Coinsurance Maximum	N/A
INN Out-of-Pocket Maximum	$5,000
Inpatient	Ded/Coins
OP Hospital	Ded/Coins
Emergency Room	$250
Urgent Care	$75
PCP	$20
Telemedicine	$10
SCP	$40
Preferred Generic	$10
Non-Preferred Generic	$20
Preferred Brand	$40
Non-Preferred Brand	$80
Preferred Specialty	30% Coins ($200 Max)
Non-Preferred Specialty	50% Coins ($200 Max)

*** IMPORTANT: Please refer to your Benefit Summary and/or SBC for more detailed benefit information**

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT
GROUP ID: PROSPECT

October 5, 2020
OPP-8096 | JT

PREMIUM RATE NOTIFICATION
HAP HMO PROSPECT OPTIONS

Renewal Date: January 1
Premium Rate Conditions Effective: January 1, 2021 through December 31, 2021

Premium Rate Conditions

PROSPECT; Premium rates are based upon the census enrollment.

Health Alliance Plan is regulated by the Department of Insurance and Financial Services (DIFS). Premium rates are conditional and subject to change based on the annual rate filing and its approval with DIFS.

Premium rates are contingent upon an employer group meeting the minimum contribution of 50% or more of the single premium.

Health Alliance Plan/Alliance Health & Life reserves the right to re-rate an employer group if the enrollment and other demographic factors of the group changes by more than 10%. This applies to not only shifts within the group's fully insured population, but also shifts in funding mechanism – for example, a fully insured group electing self-funded for a portion of their population. Final rates, taxes, and fees will be based on actual enrollment.

Illustrative premiums have been provided for informational purposes which include applicable taxes based upon current tax assessments and were developed at a fixed point in time. The actual taxes on your monthly invoice may fluctuate due to shifts in membership. In addition, pending regulatory decisions may affect the taxes applied.

Benefit descriptions are informational only. If there is a conflict between the coverage description in this report and the Summary of Benefits and Coverage or Schedule of Benefits, the terms of the Summary of Benefits and Coverage or Schedule of Benefits shall control.

Contact your HAP Account Executive for HRA or HSA information and fees.

Monthly remittance reports and payment should only be sent to the following address:
DEPARTMENT #271101 * HEALTH ALLIANCE PLAN * P.O. BOX 55000 * DETROIT, MI 48255-2711

Prepared by Underwriting Analyst: Janice Trinklein

Alliance Health and Life Insurance Company (Alliance)
Exclusive Provider Organization (EPO)
Summary of Benefits
HAP EPO 3000-20 A / Rx 7 **EPO**
PPS00051

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$3,000 Individual; $6,000 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	20%	N/A	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$4,500 Individual; $9,000 Family	N/A	These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$20 Copay - Deductible does not apply	N/A	
Telehealth Visit	$10 Copay - Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$40 Copay - Deductible does not apply	N/A	
Routine Audiology Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Chiropractic Services	$40 Copay - Deductible does not apply	N/A	Manipulation of the spine for subluxation only; Up to 20 visits per benefit period.
Allergy Treatment	20% Coinsurance after deductible	N/A	
Allergy Injections	20% Coinsurance after deductible	N/A	
Laboratory & Pathology	20% Coinsurance after deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	20% Coinsurance after deductible	N/A	Services require preauthorization.
Radiology (X-ray)	20% Coinsurance after deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	20% Coinsurance after deductible	N/A	
Dialysis	20% Coinsurance after deductible	N/A	
Outpatient Medical Drugs	20% Coinsurance after deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	20% Coinsurance after deductible	N/A	
Ambulatory Surgical Center	20% Coinsurance after deductible	N/A	
Professional Surgical and Related Services	20% Coinsurance after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$75 Copay - Deductible does not apply		
Emergency Room Care	$250 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	20% Coinsurance after deductible		Emergency transport only
Inpatient Hospital Services			
Facility Fee	20% Coinsurance after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	20% Coinsurance after deductible	N/A	
Bariatric Surgery and Related Services	20% Coinsurance after deductible	N/A	One procedure per lifetime

Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services
Postnatal Office Visits	$40 Copay - Deductible does not apply	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$20 Copay - Deductible does not apply	N/A	
Other Services			
Home Health Care	20% Coinsurance after deductible	N/A	Does not include Rehabilitation Services.; Up to 100 visits per benefit period.
Hospice Care	20% Coinsurance after deductible	N/A	Unlimited.
Skilled Nursing Care	20% Coinsurance after deductible	N/A	Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	20% Coinsurance after deductible	N/A	Covered for approved equipment only.
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids - Deductible does not apply $689 Copay per Hearing Aid for Basic Technology Hearing Aids - Deductible does not apply $989 Copay per Hearing Aid for Prime Technology Hearing Aids - Deductible does not apply $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids - Deductible does not apply $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids - Deductible does not apply	N/A	Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.
Vision Hardware	Covered - Deductible does not apply	N/A	Covered once each 12-consecutive month period. Limited to Collection Frames or Collection Contact Lenses.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$40 Copay - Deductible does not apply	N/A	May be rendered at home; Up to 60 combined visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	$40 Copay - Deductible does not apply	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	$20 Copay - Deductible does not apply	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy.
Infertility Services	20% Coinsurance after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	20% Coinsurance after deductible	N/A	One attempt per lifetime.
Temporomandibular Joint Disorder	20% Coinsurance after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Non-Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply		
Preferred Brand Drugs	$40 Copay 30 day supply, $80 Copay 90 day supply		
Non-Preferred Brand Drugs	$80 Copay 30 day supply, $160 Copay 90 day supply		
Preferred Specialty Drugs	$80 Copay 30 day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	$80 Copay 30 day supply at specialty pharmacy only		

Template Rev 01/2020

- In case of conflict between this summary and your EPO Group Health Insurance Policy and Riders, the terms and conditions of the EPO Group Health Policy and Riders will govern.
- Elective hospital admissions require that Alliance be notified prior to the admission. Alliance must be notified within 48 hours after any emergency hospital admission. Failure to notify Alliance could result in a reduction or denial of benefits.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result In a reduction or denial of benefits.
- Students away at school are covered for acute illness and injury related services according to Alliance criteria.
- EPO plans are offered through Alliance Health and Life Insurance Company, a wholly owned subsidiary of Health Alliance Plan.

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT
GROUP ID: PROSPECT

October 5, 2020
OPP-8096 | JT

PREMIUM RATE NOTIFICATION
HAP EPO PROSPECT OPTIONS

Renewal Date: January 1
Monthly Premium Rates Effective: January 1, 2021 through December 31, 2021

Rates **EXCLUDE** Taxes/Fees*

Contract Type	Contracts	HAP EPO 3000-20 A / Rx 7
Subscriber Only	69	$ 496.12
Subscriber & Spouse	46	$ 1,190.69
Subscriber & Child	0	$ 1,190.69
Subscriber & Children	0	$ 1,488.36
Subscriber, Spouse & Child(ren)	96	$ 1,488.36

Estimated Monthly Premium w/out Taxes/Fees $ 231,886.58

Check Plan Selection →

Rates **INCLUDE** Taxes/Fees*

Contract Type	Contracts	HAP EPO 3000-20 A / Rx 7
Subscriber Only	69	$ 498.52
Subscriber & Spouse	46	$ 1,196.45
Subscriber & Child	0	$ 1,196.45
Subscriber & Children	0	$ 1,495.56
Subscriber, Spouse & Child(ren)	96	$ 1,495.56

Estimated Monthly Premium with Taxes/Fees $ 233,008.34

Check Plan Selection →

*** IMPORTANT: Please see Premium Rate Conditions on Page 3**

Please sign and return to your HAP Account Executive
Tom Heidger | theidger@hap.org | (810) 230-2282

As the Executive Representative of the group listed above, my signature acknowledges the Premium Rates, Effective Dates, Plans and Premium Rate Conditions as outlined on this Rate Notification as well as the Terms and Conditions of my HAP Group Operating Agreement.

I also acknowledge
Premium rates include commission per HAP's Standard Commission Schedule
Agency Name: Walton Agency, Inc.

Authorized Signature _____

Printed Name _____

Title _____

Company _____

Date _____

We at Health Alliance Plan look forward to our continued partnership and appreciate your business.

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT
GROUP ID: PROSPECT

October 5, 2020
OPP-8096 | JT

PREMIUM RATE NOTIFICATION
HAP EPO PROSPECT OPTIONS

Renewal Date: January 1
Monthly Premium Rates Effective: January 1, 2021 through December 31, 2021

Plan Name*	**HAP EPO 3000-20 A / Rx 7**
Medical Product ID	**HAP EPO 3000-20 A / Rx 7**
Rx Product ID	
INN Deductible	$3,000
INN Coinsurance	20%
INN Coinsurance Maximum	N/A
INN Out-of-Pocket Maximum	$4,500
Inpatient	Ded/Coins
OP Hospital	Ded/Coins
Emergency Room	$250
Urgent Care	$75
PCP	$20
Telemedicine	$10
SCP	$40
Preferred Generic	$10
Non-Preferred Generic	$10
Preferred Brand	$40
Non-Preferred Brand	$80
Preferred Specialty	$80
Non-Preferred Specialty	$80

*** IMPORTANT: Please refer to your Benefit Summary and/or SBC for more detailed benefit information**

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT
GROUP ID: PROSPECT

October 5, 2020
OPP-8096 | JT

PREMIUM RATE NOTIFICATION
HAP EPO PROSPECT OPTIONS

Renewal Date: January 1
Premium Rate Conditions Effective: January 1, 2021 through December 31, 2021

Premium Rate Conditions

PROSPECT; Premium rates are based upon the census enrollment.

Health Alliance Plan is regulated by the Department of Insurance and Financial Services (DIFS). Premium rates are conditional and subject to change based on the annual rate filing and its approval with DIFS.

Premium rates are contingent upon an employer group meeting the minimum contribution of 50% or more of the single premium.

Health Alliance Plan/Alliance Health & Life reserves the right to re-rate an employer group if the enrollment and other demographic factors of the group changes by more than 10%. This applies to not only shifts within the group's fully insured population, but also shifts in funding mechanism – for example, a fully insured group electing self-funded for a portion of their population. Final rates, taxes, and fees will be based on actual enrollment.

Illustrative premiums have been provided for informational purposes which include applicable taxes based upon current tax assessments and were developed at a fixed point in time. The actual taxes on your monthly invoice may fluctuate due to shifts in membership. In addition, pending regulatory decisions may affect the taxes applied.

Benefit descriptions are informational only. If there is a conflict between the coverage description in this report and the Summary of Benefits and Coverage or Schedule of Benefits, the terms of the Summary of Benefits and Coverage or Schedule of Benefits shall control.

Contact your HAP Account Executive for HRA or HSA information and fees.

Monthly remittance reports and payment should only be sent to the following address:
DEPARTMENT #270301 * HEALTH ALLIANCE PLAN * P.O. BOX 67000 * DETROIT, MI 48267-2703

Prepared by Underwriting Analyst: Janice Trinklein

Alliance Health and Life Insurance Company (Alliance)
Preferred Provider Organization (PPO)
Summary of Benefits
HAP PPO SBP HSA 1400-0 / Rx HSA SBP **PPO**

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,400 Self Only; $2,800 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$2,800 Self Only; $5,600 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	Deductible does not include copays or coinsurance. In and Out-of-Network deductibles accumulate separately. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	20%	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$2,350 Self Only; $4,700 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$4,700 Self Only; $9,400 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	These values do not accumulate: premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified. In and Out-of-Network Out-of-Pocket Maximums accumulate separately.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	Not Covered	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	Not Covered	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	Not Covered	
Immunizations	Covered - Deductible does not apply	Not Covered	
Outpatient & Physician Services			
Primary Care Office Visit	Covered after deductible	20% Coinsurance after deductible	
Telehealth Visit	Covered after deductible	Not Covered	Through our contracted telehealth services provider.
Specialist Office Visit	Covered after deductible	20% Coinsurance after deductible	
Routine Audiology Exam	Covered - Deductible does not apply	Not Covered	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	Not Covered	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Allergy Treatment	Covered after deductible	20% Coinsurance after deductible	
Allergy Injections	Covered after deductible	20% Coinsurance after deductible	
Laboratory & Pathology	Covered after deductible	20% Coinsurance after deductible	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after deductible	20% Coinsurance after deductible	Services require preauthorization.
Radiology (X-ray)	Covered after deductible	20% Coinsurance after deductible	Some services require preauthorization.
Radiation Therapy & Chemotherapy	Covered after deductible	20% Coinsurance after deductible	
Dialysis	Covered after deductible	20% Coinsurance after deductible	Out-of-Network benefits are not covered unless Prior Authorized.
Outpatient Medical Drugs	Covered after deductible	20% Coinsurance after deductible	
Chiropractic and Massage	Covered after deductible	20% Coinsurance after deductible	Up to 38 visits per benefit period (Combined In and Out-of-Network).
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	20% Coinsurance after deductible	
Ambulatory Surgical Center	Covered after deductible	20% Coinsurance after deductible	
Professional Surgical and Related Services	Covered after deductible	20% Coinsurance after deductible	
Emergency/Urgent Care			
Urgent Care	Covered after In-Network Deductible		
Emergency Room Care	Covered after In-Network Deductible		
Emergency Medical Transportation	Covered after In-Network Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	Covered after deductible	20% Coinsurance after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	20% Coinsurance after deductible	
Bariatric Surgery and Related Services	Covered after deductible	Not Covered	One procedure per lifetime

Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	Not Covered	Covered under Preventive Services
Postnatal Office Visits	Covered after deductible	20% Coinsurance after deductible	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	See Inpatient Hospital Services	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	See Inpatient Hospital Services	
Outpatient Services	Covered after deductible	20% Coinsurance after deductible	
Other Services			
Home Health Care	Covered after deductible	20% Coinsurance after deductible	Does not include Rehabilitation Services; Up to 100 visits per benefit period (Combined In and Out-of-Network).
Hospice Care	Covered after deductible	20% Coinsurance after deductible	Unlimited.
Skilled Nursing Care	Covered after deductible	20% Coinsurance after deductible	Up to 100 days per benefit period (Combined In and Out-of-Network).
Durable Medical Equipment; Prosthetics & Orthotics	Covered after deductible	20% Coinsurance after deductible	Covered for approved equipment only.
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids after deductible $689 Copay per Hearing Aid for Basic Technology Hearing Aids after deductible $989 Copay per Hearing Aid for Prime Technology Hearing Aids after deductible $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids after deductible $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids after deductible	Not Covered	Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	20% Coinsurance after deductible	May be rendered at home; Up to 60 combined visits per benefit period (Combined In-Network and Out-of-Network).
Habilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	Not Covered	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	Covered after deductible	Not Covered	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	See Outpatient Surgical Services	Limited to vasectomy
Infertility Services	Covered after deductible	20% Coinsurance after deductible	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	Covered after deductible	20% Coinsurance after deductible	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply after deductible		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Non-Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply after deductible		
Preferred Brand Drugs	$20 Copay 30 day supply, $40 Copay 90 day supply after deductible		
Non-Preferred Brand Drugs	$40 Copay 30 day supply, $80 Copay 90 day supply after deductible		
Preferred Specialty Drugs	$40 Copay 30 day supply at specialty pharmacy only after deductible		
Non-Preferred Specialty Drugs	$40 Copay 30 day supply at specialty pharmacy only after deductible		

- In case of conflict between this summary and your PPO Group Health Insurance Policy and Riders, the terms and conditions of the PPO Group Health Insurance Policy and Riders will govern. This plan includes a network of health care providers through which services are covered at the In-Network level of benefits. If you receive covered services from a provider that is not part of the plan's network, they will be processed at the lower Out-of-Network benefit level.
- Elective hospital admissions require that Alliance be notified prior to the admission. Alliance must be notified within 48 hours after any emergency hospital admission. Failure to notify Alliance could result in a reduction or denial of benefits.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result In a reduction or denial of benefits.
- PPO plans are offered through Alliance health and Life Insurance Company, a wholly owned subsidiary of health Alliance Plan.

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT
GROUP ID: PROSPECT

October 5, 2020
OPP-8096 | JT

PREMIUM RATE NOTIFICATION
HAP PPO PROSPECT OPTIONS
Pivotal Quote

Renewal Date: January 1
Monthly Premium Rates Effective: January 1, 2021 through December 31, 2021

Rates **EXCLUDE** Taxes/Fees*

Contract Type	Contracts	HAP PPO 1400-0 HSA A / Rx 4H
Subscriber Only	69	$ 546.82
Subscriber & Spouse	46	$ 1,312.37
Subscriber & Child	0	$ 1,312.37
Subscriber & Children	0	$ 1,640.46
Subscriber, Spouse & Child(ren)	96	$ 1,640.46

Estimated Monthly Premium w/out Taxes/Fees $ 255,583.76

Check Plan Selection →

Rates **INCLUDE** Taxes/Fees*

Contract Type	Contracts	HAP PPO 1400-0 HSA A / Rx 4H
Subscriber Only	69	$ 549.22
Subscriber & Spouse	46	$ 1,318.13
Subscriber & Child	0	$ 1,318.13
Subscriber & Children	0	$ 1,647.66
Subscriber, Spouse & Child(ren)	96	$ 1,647.66

Estimated Monthly Premium with Taxes/Fees $ 256,705.52

Check Plan Selection →

*** IMPORTANT: Please see Premium Rate Conditions on Page 3**

Please sign and return to your HAP Account Executive

Tom Heidger | theidger@hap.org | (810) 230-2282

As the Executive Representative of the group listed above, my signature acknowledges the Premium Rates, Effective Dates, Plans and Premium Rate Conditions as outlined on this Rate Notification as well as the Terms and Conditions of my HAP Group Operating Agreement.

I also acknowledge
Premium rates include commission per HAP's Standard Commission Schedule
Agency Name: Walton Agency, Inc.

Authorized Signature _____

Printed Name _____

Title _____

Company _____

Date _____

We at Health Alliance Plan look forward to our continued partnership and appreciate your business.

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT
GROUP ID: PROSPECT

October 5, 2020
OPP-8096 | JT

PREMIUM RATE NOTIFICATION

HAP PPO PROSPECT OPTIONS

Pivotal Quote

Renewal Date: January 1
Monthly Premium Rates Effective: January 1, 2021 through December 31, 2021

Plan Name*	**HAP PPO 1400-0 HSA A / Rx 4H**
Medical Product ID	**HAP PPO 1400-0 HSA A / Rx 4H**
Rx Product ID	
INN Deductible	$1,400
INN Coinsurance	0%
INN Coinsurance Maximum	N/A
INN Out-of-Pocket Maximum	$2,800
OON Deductible	$2,800
OON Coinsurance	20%
OON Coinsurance Maximum	N/A
OON Out-of Pocket Maximum	$5,600
Inpatient	Ded/Coins
OP Hospital	Ded/Coins
Emergency Room	Ded/Coins
Urgent Care	Ded/Coins
PCP	Ded/Coins
Telemedicine	Ded/Coins
SCP	Ded/Coins
Preferred Generic	Ded then $10 Copay
Non-Preferred Generic	Ded then $10 Copay
Preferred Brand	Ded then $40 Copay
Non-Preferred Brand	Ded then $80 Copay
Preferred Specialty	Ded then $80 Copay
Non-Preferred Specialty	Ded then $80 Copay

*** IMPORTANT: Please refer to your Benefit Summary and/or SBC for more detailed benefit information**

GROUP NAME: JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT-JCISD SEGMENT **October 5, 2020**
GROUP ID: PROSPECT **OPP-8096 | JT**

PREMIUM RATE NOTIFICATION
HAP PPO PROSPECT OPTIONS

Renewal Date: January 1
Premium Rate Conditions Effective: January 1, 2021 through December 31, 2021

Premium Rate Conditions
PROSPECT; Premium rates are based upon the census enrollment.

Health Alliance Plan is regulated by the Department of Insurance and Financial Services (DIFS). Premium rates are conditional and subject to change based on the annual rate filing and its approval with DIFS.

Premium rates are contingent upon an employer group meeting the minimum contribution of 50% or more of the single premium.

Health Alliance Plan/Alliance Health & Life reserves the right to re-rate an employer group if the enrollment and other demographic factors of the group changes by more than 10%. This applies to not only shifts within the group's fully insured population, but also shifts in funding mechanism – for example, a fully insured group electing self-funded for a portion of their population. Final rates, taxes, and fees will be based on actual enrollment.

Illustrative premiums have been provided for informational purposes which include applicable taxes based upon current tax assessments and were developed at a fixed point in time. The actual taxes on your monthly invoice may fluctuate due to shifts in membership. In addition, pending regulatory decisions may affect the taxes applied.

Benefit descriptions are informational only. If there is a conflict between the coverage description in this report and the Summary of Benefits and Coverage or Schedule of Benefits, the terms of the Summary of Benefits and Coverage or Schedule of Benefits shall control.

Contact your HAP Account Executive for HRA or HSA information and fees.

Monthly remittance reports and payment should only be sent to the following address:
DEPARTMENT #270301 * HEALTH ALLIANCE PLAN * P.O. BOX 67000 * DETROIT, MI 48267-2703

Prepared by Underwriting Analyst: Janice Trinklein

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits
HAP HMO 1400-0 HSA A Pivotal / Rx 4H **HMO**

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,400 Self Only; $2,800 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$2,800 Self Only; $5,600 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	N/A	These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	Covered after deductible	N/A	
Telehealth Visit	Covered after deductible	N/A	Virtual care through Affiliated Providers participating in the Pivotal Product only
Specialist Office Visit	Covered after deductible	N/A	
Routine Audiology Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	N/A	One exam per Benefit Period.; For non-routine visits see Specialist Office Visit.
Chiropractic Services	Covered after deductible	N/A	Manipulation of the spine for subluxation only; Up to 20 visits per benefit period.
Allergy Treatment	Covered after deductible	N/A	
Allergy Injections	Covered after deductible	N/A	
Laboratory & Pathology	Covered after deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after deductible	N/A	Services require preauthorization.
Radiology (X-ray)	Covered after deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	Covered after deductible	N/A	
Dialysis	Covered after deductible	N/A	
Outpatient Medical Drugs	Covered after deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	N/A	
Ambulatory Surgical Center	Covered after deductible	N/A	
Professional Surgical and Related Services	Covered after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	Covered after deductible		
Emergency Room Care	Covered after deductible		
Emergency Medical Transportation	Covered after deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	Covered after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	N/A	
Bariatric Surgery and Related Services	Covered after deductible	N/A	One procedure per lifetime

Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services
Postnatal Office Visits	Covered after deductible	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	Covered after deductible	N/A	
Other Services			
Home Health Care	Covered after deductible	N/A	Does not include Rehabilitation Services; Up to 100 visits per benefit period.
Hospice Care	Covered after deductible	N/A	Unlimited.
Skilled Nursing Care	Covered after deductible	N/A	Covered for authorized services; Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	Covered after deductible	N/A	Covered for approved equipment only.
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids after deductible $689 Copay per Hearing Aid for Basic Technology Hearing Aids after deductible $989 Copay per Hearing Aid for Prime Technology Hearing Aids after deductible $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids after deductible $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids after deductible	N/A	Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.
Vision Hardware	Covered - Deductible does not apply	N/A	Covered once each 12-consecutive month period. Limited to Collection Frames or Collection Contact Lenses.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	N/A	May be rendered at home; Up to 60 combined visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Applied Behavioral Analysis	Covered after deductible	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy.
Infertility Services	Covered after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	Covered after deductible	N/A	One attempt per lifetime.
Temporomandibular Joint Disorder	Covered after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply after deductible		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Non-Preferred Generic Drugs	$10 Copay 30 day supply, $20 Copay 90 day supply after deductible		
Preferred Brand Drugs	$40 Copay 30 day supply, $80 Copay 90 day supply after deductible		
Non-Preferred Brand Drugs	$80 Copay 30 day supply, $160 Copay 90 day supply after deductible		
Preferred Specialty Drugs	$80 Copay 30 day supply at specialty pharmacy only after deductible		
Non-Preferred Specialty Drugs	$80 Copay 30 day supply at specialty pharmacy only after deductible		

- In case of conflict between this summary and your HMO Subscriber Contract and Riders, the terms and conditions of the HMO Subscriber Contract and Riders will govern.
- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours after any emergency hospital admission. Failure to notify HAP could result in a reduction or denial of benefits.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.
- Students away at school are covered for acute illness and injury related services according to HAP criteria.