

PRIORITY HEALTH
priorityhealth.com
PRIORITYHSASM POINT OF SERVICE (POS) PRODUCT
East Jordan Public Schools Group #782763
January 1, 2010 through December 31, 2010

The Point-of-Service plan offers you a choice of two benefit levels. The **Preferred Benefit** level applies when your Primary Care Provider (PCP) or other Participating Physician coordinates all of your medical care. Your out-of-pocket costs are lower when you use this option. The **Alternate Benefit** level applies when you seek medical services without coordinating with your PCP or other Participating Physician and when you use out-of-network services without receiving prior approval from Priority Health. Services you receive that are excluded from coverage are not paid at either benefit level.

The following information is provided as a summary of benefits available under your Point-of-Service plan. This summary is not intended as 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 Certificate of Coverage from Priority Health's Customer Service Department at 616 942-1221 or 800 446-5674 or on-line at 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	Preferred Benefit – 100% Plan	Alternate Benefit – 80/20% Plan
<p>The Deductible is the amount of Covered Services you must incur during the Contract Year before benefits will be paid.</p> <p>Deductible amounts satisfied under the Preferred Benefit Level do not apply toward the Alternate Benefit Level deductible and vice versa.</p>	<p>The Deductible is applicable to all Covered Services <u>except</u> routine maternity care services and preventive health care services that are listed in Priority Health's Preventive Healthcare Guidelines. Charges for delivery are subject to the Deductible.</p>	<p>The Deductible is applicable to all Covered Services.</p>
<p>Individual Contract and Family Contract Deductibles:</p> <ul style="list-style-type: none"> • 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. <p>Your Deductible renews each Contract Year.</p>		
<p>Notwithstanding the above, the following costs do not apply towards the Deductible: Services that exceed the annual day or dollar benefit maximum for a specific benefit (denied as non-Covered Services) and penalties paid for failure to preauthorize services.</p>		
<p>Prior to January 1, 2006, your Deductibles will not take into account any monies paid under your prescription drug rider. Effective January 1, 2006, your Preferred Benefits Deductible will take into account any monies paid under your prescription drug rider. See your prescription drug rider for more details.</p>		
Individual Deductible per Contract Year	\$1,200	\$3,000
Family Deductible per Contract Year	\$2,400	\$6,000

Out-of-Pocket Maximums	Preferred Benefit – 100% Plan	Alternate Benefit – 80/20% Plan
<p>The Out-of-Pocket Maximum limits the total amount that you will pay toward Covered Services during a Contract Year.</p> <p>If you have an Individual Contract, when calculating your Out-of-Pocket Maximum, Priority Health will include all Copayment and Deductibles paid toward Covered Services during a Contract Year. If you have a Family Contract, Priority Health will include all Copayments and Deductibles you and your family paid collectively toward Covered Services during a Contract Year.</p>	<p>Once the applicable Out-of-Pocket Maximum is met, all further medical Covered Services for that Contract Year will be paid at 100% of Priority Health’s contracted rate.</p>	<p>Once the Out-of-Pocket Maximum is met, all further medical Covered Services for that Contract Year will be paid at 100% of the lesser of billed charges or Reasonable and Customary Charges.</p>
<p>Notwithstanding the above, the following out-of-pocket costs do not apply toward the Out-of-Pocket Maximum: Services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-Covered Services); Penalties paid for failure to preauthorize services; and, Costs paid by member to provider for Alternate Benefits that exceed Reasonable and Customary. A Copayment shall not exceed 50% of Priority Health’s reimbursement to a provider for Covered Services a member receives.</p>		
Individual Out-of-Pocket Maximum per Contract Year	\$2,000	\$4,000
Family Out-of-Pocket Maximum per Contract Year	\$4,000	\$8,000
Maximum Individual Lifetime Benefit	Not Applicable	\$1,000,000
<p>Note: Priority Health Benefit Maximum: Coverage maximums up to a certain number of days/visits per Contract Year are reached by combining either Preferred or Alternate Benefits up to the limit for one or the other, but not both. (Example: If Preferred Benefit is for 60 visits and Alternate Benefit is for 60 visits, the maximum benefit is 60 visits, not 120 visits).</p>		
Basic Benefits	Preferred Benefit – 100% Plan Deductible applies where indicated below	Alternate Benefit – 80/20%* Plan *Percentage Coverage is calculated using the lower of billed charges or Reasonable and Customary Charges for Covered Services.
Physician’s Services		
PCP and other Participating Physician (Includes all office and home visits not considered preventive health care services or routine maternity care services)	100% Coverage. Deductible applies.	80% Coverage. Deductible applies.
Preventive Health Care Services (Preventive health care services are those services listed in Priority Health’s preventive health care guidelines. These services must be provided by your PCP or a Participating Physician and prior approval from Priority Health if necessary.)	Services Covered in Full – No Office Copayment	80% Coverage. Deductible applies.
Routine Maternity Care Services Prenatal and Postnatal Deductible applies to all charges for delivery.	No Office Visit Copayment for routine pre- and postnatal visits. Deductible applies to all other services.	80% Coverage. Deductible applies.

Basic Benefits	Preferred Benefit – 100% Plan Deductible applies where indicated below	Alternate Benefit – 80/20%* Plan *Percentage Coverage is calculated using the lower of billed charges or Reasonable and Customary Charges for Covered Services.
Physician's Services (continued)		
Allergy Testing and Injections	100% Coverage. Deductible applies.	80% Coverage. Deductible applies.
Outpatient Services Diagnostic Laboratory and X-Ray Chemotherapy Radiation Therapy Hemodialysis	100% Coverage. Deductible applies. 100% Coverage. Deductible applies. 100% Coverage. Deductible applies. 100% Coverage. Deductible applies.	80% Coverage. Deductible applies.
Rehabilitative Medicine Services		
Physical and Occupational Therapy (including spinal manipulation)	100% Coverage per visit up to a combined benefit maximum of 50 visits per Contract Year. Deductible applies.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 50 visits per Contract Year
Speech Therapy	100% Coverage per visit up to a combined benefit maximum of 50 visits per Contract Year. Deductible applies.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 50 visits per Contract Year
Cardiac Rehabilitation and Pulmonary Rehabilitation	100% Coverage per visit up to a combined benefit maximum of 50 visits per Contract Year. Deductible applies.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 50 visits per Contract Year
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.	80% Coverage. Deductible applies. Pre-approval required or 20% penalty applies.
Inpatient Hospital Professional Services	100% Coverage. Deductible applies.	80% Coverage. Deductible applies. Pre-approval required or 20% penalty 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.	80% Coverage. Deductible applies. Pre-approval required or 20% penalty applies.
Outpatient Hospital Professional Services	100% Coverage. Deductible applies.	80% Coverage. Deductible applies. Pre-approval required or 20% penalty applies. Prior approval is required for certain radiology examinations.

Basic Benefits	Preferred Benefit – 100% Plan Deductible applies where indicated below	Alternate Benefit – 80/20%* Plan *Percentage Coverage is calculated using the lower of billed charges or Reasonable and Customary Charges for Covered Services.
Hospital Services (continued)		
Certain Surgeries and Treatments (Physician fees only) Bariatric surgery* (limit one per lifetime) Reconstructive surgery: blepharoplasty of upper eyelids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty* and surgical treatment of male gynecomastia Skin Disorder Treatments: Scar revisions, keloid scar treatment, treatment of hyperhidrosis, excision of lipomas, excision of seborrhic keratoses, excision of skin tags, treatment of vitiligo and port wine stain and hemangioma treatment. Varicose veins treatments Sleep apnea treatment procedures*	Physician fees are Covered at 50%, after deductible, of the first \$2,000.00 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures.	Physician fees are Covered at 50%, after deductible, of the first \$3,000.00 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures.
Emergency Medical Care (in or out of the service area)		
Hospital Emergency Room	100% Coverage. Deductible applies.	100% Coverage. Deductible applies.
Urgent Care Center	100% Coverage. Deductible applies.	100% Coverage. Deductible applies.
Physician's Office	100% Coverage. Deductible applies.	80% Coverage. Deductible applies.
Ambulance (land or air)	100% Coverage. Deductible applies.	100% Coverage. Deductible applies.
Family Planning/Infertility Services (Family Planning and Infertility Services are covered under the Preferred Benefit only.)		
Vasectomy	100% Coverage when performed in a provider's office or when in connection with other covered inpatient or outpatient surgery. Deductible applies.	Not Covered
Tubal Ligation		
Professional Fees	100% Coverage. Deductible applies.	Not Covered
Outpatient	100% Coverage. Deductible applies.	Not Covered
Inpatient	100% Coverage when performed in connection with delivery or other covered inpatient surgery. Deductible applies.	Not Covered
Infertility services for diagnostic, counseling and planning services for treatment of the underlying cause of infertility.	50% Coverage. Deductible applies. Prescription drugs for infertility treatment covered only with prescription drug rider.	Not Covered
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 & Substance Abuse Services (including rehabilitation and partial hospitalization)	100% Coverage. Deductible applies.	80% Coverage Deductible applies. Failure to obtain prior approval will result in 20% reduction in benefits.

Basic Benefits	Preferred Benefit – 100% Plan Deductible applies where indicated below	Alternate Benefit – 80/20%* Plan *Percentage Coverage is calculated using the lower of billed charges or Reasonable and Customary Charges for Covered Services.
Outpatient Mental Health & Substance Abuse Services (including medication management visits)	100% Coverage. Deductible applies.	80% Coverage. Deductible applies.
Other Services		
Durable Medical Equipment	100% Coverage. Deductible applies.	50% Coverage. Deductible applies.
Prosthetics & Orthotics	100% Coverage. Deductible applies.	50% Coverage. Deductible applies.
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	100% Coverage. Deductible applies. Maximum 90 days per Contract Year. Prior approval required.	80% Coverage up to 45 days per Contract Year. Failure to obtain prior approval will result in 20% reduction in benefits. Deductible applies.
Home Health Care	100% Coverage. Deductible applies. For rehabilitative therapy provided in the home, refer to Short-Term Rehabilitative services for Copayment information.	80% Coverage. Deductible applies.
Temporomandibular Joint Syndrome (TMJS)	50% Coverage. Deductible applies.	50% Coverage. Deductible applies.
Orthognathic Surgery	50% Coverage. Deductible applies.	50% Coverage. Deductible applies.
Additional Benefits		
Pharmacy Services		
Prescription Drugs Note: Prescription drug coverage is based on the usage of a medication formulary.	Covered with a \$10 Generic/\$40 Brand Name Copayment per prescription. Includes prescription contraceptive drugs and implantable contraceptive drugs. Contraceptive devices administered or supplied in the physician's office are covered at 50%. Does not cover condoms, foams, jellies, ointments and other drugs or devices available over the counter. Infertility drugs covered with a 50% Copayment. (Limitations apply) Deductible applies.	Preferred Benefit Only
Prescription Mail Order	Prescription drugs filled for up to 90 days with a \$20 Generic/\$80 Brand Name Copayment per prescription. Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply) Deductible applies	Preferred Benefit Only

Eligibility Information		
Dependent Children	Covered until the end of the year in which dependent turns age 19. Additionally, covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or reaches the age of 25.	Covered until the end of the year in which dependent turns age 19. Additionally, covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or reaches the age of 25.
Early Retiree Coverage	Not Available	Not Available
65+ Retiree Coverage	Not Available	Not Available