

PRIORITY HEALTH
priorityhealth.com
PRIORITYPOSSM (POINT OF SERVICE) PRODUCT
Traverse City Area Public Schools Non-Affiliated Support Staff Low Option
June 1, 2009 through May 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 – 80/20% Plan	Alternate Benefit – 60/40% Plan
<p>A Deductible is the amount of covered expenses you must incur during the Contract Year before benefits will be paid. Deductible amounts you pay are excluded from any out-of-pocket maximums.</p> <p>Deductible amounts satisfied under the Preferred Benefit Level do not apply toward the Alternate Benefit Level deductible and vice versa.</p> <p>Any Deductible amounts satisfied during the ninety (90) days preceding the start of a new Contract Year will carry over into the new Contract Year.</p>	<p>The Deductible is applicable to all covered services except routine maternity care, services received in your PCP's office, or preventive healthcare services that are listed in Priority Health's Preventive Healthcare Guidelines. Facility charges for delivery are subject to the Deductible.</p>	<p>The Deductible is applicable to all covered services.</p>
<p>Note: Services applied to Individual Deductible will be combined to satisfy the Family Deductible. The Family Deductible is not to exceed the Individual Deductible per person.</p>		
Individual Deductible per Contract Year	\$250	\$500
Family Deductible per Contract Year	\$500	\$1,000

Maximums	Preferred Benefit – 80/20% Plan	Alternate Benefit – 60/40% Plan
<p>Note: Out-of-Pocket maximum is the amount of covered expenses that you and/or your covered dependents will pay.</p> <p>Only Coinsurance for inpatient and outpatient facility services applies to out-of-pocket maximum.</p>	<p>If the individual out-of-pocket maximum is reached during a Contract Year, Priority Health will pay 100% of covered hospital expenses incurred by that person for the rest of the Contract Year. If the family maximum is reached during a Contract Year, Priority Health will pay 100% of covered hospital expenses for you and all of your covered dependents for the rest of that Contract Year.</p>	<p>Out-of-Pocket maximum is \$3,000 per individual and \$6,000 per family. All services apply to out-of-pocket maximums except Durable Medical Equipment; Prosthetic & Orthotic Devices; Treatment of Temporomandibular Joint Syndrome; Orthognathic Surgery Services; Family Planning/Infertility Services; Mental Health, Substance Abuse Services, any flat dollar Copayments, such as Copayments for office visits, ambulance and emergency services, Port Wine Stains, Certain Surgeries Professional Fees and Penalty charges.</p>
Individual Out-of-Pocket Maximum per Contract Year	\$800	\$3,000
Family Out-of-Pocket Maximum per Contract Year	\$2,400	\$6,000
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). The Family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person.</p>		
Basic Benefits	Preferred Benefit – 80/20% Plan	Alternate Benefit – 60/40% Plan
	Deductible applies to all services except where indicated below	Deductible applies to all services
Physician's Services		
Primary Care Provider (PCP) Office Visit (services provided by your PCP and other Participating Physician or during an office visit for health maintenance and preventive care, such as a routine physical, or for the diagnosis and treatment of a covered illness or injury)	\$10 Copayment per visit. Deductible does not apply to PCP visits. Lab or X-ray services sent to another facility for analysis covered at 80%. Deductible may apply if lab/X-ray services are not considered preventive care under Priority Health's Preventive Healthcare Guidelines.	60% Coverage of reasonable and customary charges. Lab or X-ray services sent to another facility for analysis covered at 60%.
Specialist Office Visit (referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary)	\$10 Copayment per visit. Deductible applies. Lab or X-ray services sent to another facility for analysis covered at 80%. Deductible applies.	60% Coverage of reasonable and customary charges. Lab or X-ray services sent to another facility for analysis covered at 60%.
Routine Pre and Post-natal Care	\$10 Copayment per visit. Maximum Copayment of \$60 per pregnancy. (Deductible does not apply to routine maternity.)	60% Coverage of reasonable and customary charges
Allergy Care	100% Coverage for injections and serum. Applicable office visit Copayment may apply for testing. Deductible applies.	60% Coverage of reasonable and customary charges

Basic Benefits	Preferred Benefit – 80/20% Plan	Alternate Benefit – 60/40% Plan
Physician's Services (continued)		
Outpatient Services Diagnostic Laboratory and X-Ray Chemotherapy Radiation Therapy Hemodialysis	80% Coverage. Deductible applies. 80% Coverage. Deductible applies. 80% Coverage. Deductible applies. 80% Coverage. Deductible applies.	60% Coverage of reasonable and customary charges
Rehabilitative Medicine Services		
Physical and Occupational Therapy (including spinal manipulation)	\$10 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year. Deductible applies.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 30 visits per Contract Year
Speech Therapy	\$10 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year. Deductible applies.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 30 visits per Contract Year
Cardiac Rehabilitation and Pulmonary Rehabilitation	\$10 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year. Deductible applies.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 30 visits per Contract Year
Note: If the above outpatient services are performed and processed in a physician's office, only the applicable office visit Copayment 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.	80% Coverage. Deductible applies.	60% Coverage of reasonable and customary charges. Pre-approval required or 20% penalty applies. Penalty charges do not apply to out-of-pocket maximums.
Inpatient Hospital Professional Services	100% Coverage. Deductible applies.	60% Coverage of reasonable and customary charges. Pre-approval required or 20% penalty applies. Penalty charges do not apply to out-of-pocket maximums.
Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services)	80% Coverage. Deductible applies. Prior approval is required for certain radiology examinations.	60% Coverage of reasonable and customary charges. Pre-approval required or 20% penalty applies. Penalty charges do not apply to out-of-pocket maximums
Outpatient Hospital Professional Services	100% Coverage. Deductible applies.	60% Coverage of reasonable and customary charges. Pre-approval required or 20% penalty applies. Penalty charges do not apply to out-of-pocket maximums.
Certain Surgeries and Treatments (Physician fees only) Bariatric surgery* (limit one per lifetime) Reconstructive surgery: blepharoplasty of upper lids, 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 seborrheic 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% of the first \$2,000.00 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. Deductible applies. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures.	Physician fees are Covered at 50% of the first \$3,000.00 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. Deductible applies. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures.

Basic Benefits	Preferred Benefit – 80/20% Plan	Alternate Benefit – 60/40% Plan
Emergency Medical Care (in or out of the service area)		
Hospital Emergency Room	\$50 Copayment per visit (waived if admitted). Deductible applies.	\$50 Copayment per visit (waived if admitted)
Urgent Care Center	\$10 Copayment per visit. Deductible applies.	60% Coverage of reasonable and customary charges
Physician's Office	\$10 Copayment per visit. Deductible applies.	60% Coverage of reasonable and customary charges
Ambulance (land or air)	\$0 Copayment. Deductible applies.	\$0 Copayment
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 80% Coverage when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.	Not Covered
Tubal Ligation		
Professional Fees	100% Coverage. Deductible applies.	Not Covered
Outpatient	80% Coverage. Deductible applies.	Not Covered
Inpatient	80% 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 Services	80% Coverage. Deductible applies. Maximum 45 days per Contract Year.	60% Coverage of reasonable and customary charges up to 20 days per Contract Year.
Outpatient Mental Health Services	\$20 Copayment. Deductible applies. Maximum 35 visits per Contract Year. (\$10 Copayment per group therapy visit – two group therapy visits counts as one outpatient visit.)	50% Coverage of reasonable and customary charges per visit up to 20 visits per Contract Year. (\$10 Copayment per group therapy visit – two group therapy visits counts as one outpatient visit.)
Substance Abuse Services	80% Coverage up to \$4,800 or the minimum annual benefit as determined by the State of Michigan per Contract Year, whichever is greater. Deductible applies.	60% Coverage of reasonable and customary charges up to \$4,800 or the minimum annual benefit as determined by the State of Michigan per Contract Year, whichever is greater.
Other Services		
Durable Medical Equipment	80% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Prosthetics & Orthotics	80% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	80% Coverage. Deductible applies. Maximum 45 days per Contract Year.	60% Coverage of reasonable and customary charges up to 45 days per Contract Year. Must be prior approved or 20% penalty will apply.
Home Health Care	Covered in full. Deductible applies.	60% Coverage of reasonable and customary charges

Basic Benefits	Preferred Benefit – 80/20% Plan	Alternate Benefit – 60/40% Plan
Other Services (continued)		
Temporomandibular Joint Syndrome (TMJS)	50% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Orthognathic Surgery	50% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Additional Benefits		
Pharmacy Services	Deductible does not apply	Deductible does not apply
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)	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)
Prescription Mail Order	Prescription drugs filled for up to 90 days with a \$10 Generic/\$40 Brand Name Copayment per prescription. (Limitations apply)	Prescription drugs filled for up to 90 days with a \$10 Generic/\$40 Brand Name Copayment per prescription. (Limitations apply)
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.
Sponsored Dependent	Coverage for eligible dependents (as defined by group) who are legally related to subscriber and reside with subscriber, and who are not eligible for Medicare or Medicaid.	Coverage for eligible dependents (as defined by group) who are legally related to subscriber and reside with subscriber, and who are not eligible for Medicare or Medicaid.
Early Retiree Coverage	Not Available	Not Available
65+ Retiree Coverage	Not Available	Not Available