PRIORITY HEALTH
priorityhealth.com
PRIORITYPOS℠ (POINT OF SERVICE) PRODUCT
KALAMAZOO COLLEGE - #786919
In Area Employees
1/1/2011 – 12/31/2011

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**
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. Deductible amounts satisfied under the Preferred Benefit Level do not apply toward the Alternate Benefit Level deductible and vice versa. 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.	Not Applicable	The Deductible is applicable to all covered services.
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.		
Individual Deductible per Contract Year	Not Applicable	$500
Family Deductible per Contract Year	Not Applicable	$1,000

Maximums	Preferred Benefit – 100% Plan	Alternate Benefit – 80/20% Plan
Note: Out-of-Pocket maximum is the amount of covered expenses that you and/or your covered dependents will pay. Only Coinsurance for inpatient and outpatient facility services applies to out-of-pocket maximum.	Not Applicable	Out-of-Pocket maximum is $1,500 per individual and $3,000 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; Rehabilitative Medicine Visits, any flat dollar Copayments, such as Copayments for office visits, ambulance and emergency services, Port Wine Stains, Certain Surgeries Professional Fees and Penalty charges.
Individual Out-of-Pocket Maximum per Contract Year	Not Applicable	$1,500
Family Out-of-Pocket Maximum per Contract Year	Not Applicable	$3,000
Maximum Individual Annual Benefit	Not Applicable	$1,000,000
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.		

Basic Benefits	Preferred Benefit – 100% Plan	Alternate Benefit – 80/20% Plan
		Deductible applies to all services
Physician's Services		
Primary Care Provider (PCP) Office Visit (face-to-face, telephonic or through secure electronic portal 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, $0 Preventive Care Copayment.	80% Coverage of reasonable and customary charges for face-to-face visits only. Lab or X-ray services sent to another facility for analysis covered at 80%.
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.	80% Coverage of reasonable and customary charges. Lab or X-ray services sent to another facility for analysis covered at 80%.
Routine Pre and Post-natal Care	$10 Copayment per visit. Maximum Copayment of $60 per pregnancy.	80% Coverage of reasonable and customary charges
Allergy Care	100% Coverage for injections and serum. Applicable office visit Copayment may apply for testing.	80% Coverage of reasonable and customary charges

Basic Benefits	Preferred Benefit – 100% Plan	Alternate Benefit – 80/20% Plan
Physician's Services (continued)		
Outpatient Services Diagnostic Laboratory and X-Ray Chemotherapy Radiation Therapy Hemodialysis	 100% Coverage. 100% Coverage. 100% Coverage. 100% Coverage.	 80% Coverage of reasonable and customary charges
Rehabilitative Medicine Services		
Physical and Occupational Therapy (including **osteopathic and chiropractic** manipulation)	$10 Copayment per visit up to a combined benefit maximum of 50 visits per Contract Year.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 50 visits per Contract Year
Speech Therapy	$10 Copayment per visit up to a combined benefit maximum of 50 visits per Contract Year.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 50 visits per Contract Year
Cardiac Rehabilitation and Pulmonary Rehabilitation	$10 Copayment per visit up to a combined benefit maximum of 50 visits per Contract Year.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 50 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.	100% Coverage.	80% 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.	80% 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)	100% Coverage. Prior approval is required for certain radiology examinations.	80% 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.	80% 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. *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 bariatrric surgery, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures.

Basic Benefits	Preferred Benefit – 100% Plan	Alternate Benefit – 80/20% Plan
Emergency Medical Care (in or out of the service area)		
Hospital Emergency Room	$150 Copayment per visit (waived if admitted).	$150 Copayment per visit (waived if admitted)
Urgent Care Center	$10 Copayment per visit.	80% Coverage of reasonable and customary charges
Physician's Office	$10 Copayment per visit.	80% Coverage of reasonable and customary charges
Ambulance (land or air)	$0 Copayment.	$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 when in connection with other covered inpatient or outpatient surgery.	Not Covered (including physicians' fees and any other related charges)
Tubal Ligation		
Professional Fees	100% Coverage.	Not Covered (including physicians' fees and any other related charges)
Outpatient	100% Coverage.	Not Covered (including physicians' fees and any other related charges)
Inpatient	100% Coverage when performed in connection with delivery or other covered inpatient surgery.	Not Covered (including physicians' fees and any other related charges)
Infertility services for diagnostic, counseling and planning services for treatment of the underlying cause of infertility	50% Coverage. Prescription drugs for infertility treatment covered only with prescription drug rider.	Not Covered (including physicians' fees and any other related charges)
Behavioral Health Services **Note:** Contact Priority Health's Behavioral Health Department at 616 464-8500 or 800 673-8043 if you have questions about your Mental Health and Substance Abuse benefits or coverage.		
Inpatient Mental Health and Substance Abuse Services (including rehabilitation and partial hospitalization)	100% Coverage.	80% Coverage of reasonable and customary charges Failure to obtain prior approval will result in a 20% reduction of benefits.
Outpatient Mental Health and Substance Abuse Services (including medication management)	$10 Copayment.	80% Coverage of reasonable and customary charges per visit
Other Services		
Durable Medical Equipment	100% Coverage.	50% Coverage of reasonable and customary charges
Prosthetics & Orthotics	100% Coverage.	50% Coverage of reasonable and customary charges
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	100% Coverage. Maximum 120 days per Contract Year.	80% 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 (including Hospice Services, excluding Rehabilitative Medicine)	Covered in full.	80% Coverage of reasonable and customary charges
Temporomandibular Joint Syndrome (TMJS)	50% Coverage.	50% Coverage of reasonable and customary charges
Orthognathic Surgery	50% Coverage.	50% Coverage of reasonable and customary charges

Additional Benefits		
Pharmacy Services		
Prescription Drugs **Note:** Prescription drug coverage is based on the usage of a medication formulary. 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.	**Tier 1- Generic Drugs** $10 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $20 Copay per prescription or refill for a Preferred Brand-Name Drug **Infertility Treatment** 50% Copay for drugs used for treating infertility. (Limitations apply)	**Tier 1- Generic Drugs** $10 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $20 Copay per prescription or refill for a Preferred Brand-Name Drug **Infertility Treatment** 50% Copay for drugs used for treating infertility. (Limitations apply)
Prescription Mail Order Filled for up to 90 days Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply)	**Tier 1- Generic Drugs** $20 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $40 Copay per prescription or refill for a Preferred Brand-Name Drug	**Tier 1- Generic Drugs** $20 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $40 Copay per prescription or refill for a Preferred Brand-Name Drug
Elective Termination	Voluntary termination of pregnancy in first trimester. 50% Copayment. Limit of one procedure in any 24 consecutive months.	Not Covered.

Eligibility Information		
Dependent Children	Covered until dependent reaches age 26, regardless of student status.	Covered until dependent reaches age 26, regardless of student status.
Early Retiree Coverage	Available	Available
65+ Retiree Coverage	Not Available	Not Available
Domestic Partners (Enhanced)	Dependent coverage when two individuals of the same or opposite gender live together in a long-term relationship of indefinite duration with an exclusive mutual commitment similar to that of marriage. Eligibility as determined by group.	Dependent coverage when two individuals of the same or opposite gender live together in a long-term relationship of indefinite duration with an exclusive mutual commitment similar to that of marriage. Eligibility as determined by group.

11/15/2010 CMS

PriorityHealth

Non-Grandfathered HMO/POS/EPO large business benefit summary attachment for Health Care Reform 2010

The updates below reflect changes to the attached Benefit Summary based on the Patient Protection and Affordable Care Act (PPACA) and its subsequent regulations.

Preventive Care

Medical

Items on the Priority Health Preventive Care Guidelines are covered with $0 copay: http://www.priorityhealth.com/healthwellness/prevention/guidelines.

Pharmaceutical

Preventive care prescription drugs are covered 100%.

Coverage for Emergency Service

No changes.

Extension of Dependent Coverage

Covered until dependent turns age 26.

- Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in this Priority Health plan. Individuals may request enrollment for such children during a 30 day open enrollment period as specified by your employer. If your employer does not offer an open enrollment period before your plan effective date, enrollment will be effective retroactively.

Lifetime Limits (applies to POS and PPO only)

Lifetime limits are replaced by for out of network services unless in-network services are unavailable. Individuals may request enrollment during a 30-day open enrollment period as specified by your employer.