PriorityHealth
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PRIORITY HSA - POS
Summary of Benefits
ONEKAMA CONSOLIDATED SCHOOLS
10/1/2011 - 9/30/2012

The Point-of-Service plan offers you a choice of two benefit levels. The **Preferred Benefits** are the benefits provided by Priority Health under this Certificate when a Member's PCP or other Participating Physician coordinates his or her care. Benefits are paid according to the Schedule of Copayments and Deductibles. The **Alternate Benefits** are provided when a Member chooses to direct his or her own care to a Non-Participating Provider. Benefits are paid according to the Schedule of Copayments and Deductibles.

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 Benefits - 100% Plan**	**Alternate Benefits - 70%/30% Plan**
A Deductible is the amount of covered expenses you must incur during the Contract Year before benefits will be paid. The Deductible is applicable to all covered services except: • Routine Maternity Care (the Deductible does apply to facility charges for delivery). • Preventive health care services. Individual Contract and Family Contract Deductibles: • If you are the only individual on your contract, you have an Individual Contract and the Individual Contract Deductible applies. • If you have more than one individual on your contract, you have a Family Contract and only the Family Contract Deductible Applies. The Family Contract Deductible can be satisfied by any one family member or by any combination of family members. Deductible amounts you pay are included in your out-of-pocket maximum. Deductible amounts satisfied under the Preferred Benefit Level do not apply toward the Alternate Benefit Level Deductible and vice versa. Your deductible renews each Contract Year.		
Individual Deductible per Contract Year	$1,200	$3,000
Family Deductible per Contract Year	$2,400	$6,000

Maximums	Preferred Benefits - Plan	Alternate Benefits - 70%/30% Plan
Note: Out-of-Pocket maximum is the amount of covered expenses that you and/or your covered dependents will pay. If you have an Individual Contract, when calculating your Out-of-Pocket Maximum, we will include all Copayments and Deductibles you paid toward medical Covered Services during a Contract Year. If you have a Family Contract, we will include all Copayments and Deductibles you and your family paid collectively toward medical Covered Services during a Contract Year. Once the applicable Out-of-Pocket Maximum is met, all further medical Covered Services for that Contract Year will be paid by Priority Health at 100% without requirement of Copayment. Your Out-of-Pocket Maximum limit renews each Contract Year.		
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 Annual Benefit	Not Applicable	$1,000,000

LIFETIME MAXIMUM REQUIRED NOTICE

The lifetime limit on the dollar value of benefits no longer applies. Individuals whose coverage ended by reason of reaching a combined lifetime limit are eligible to enroll in this plan. Individuals may enroll during the group's next open enrollment period or within 30 days after the group's next renewal.

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).

Basic Benefits	Preferred Benefits - Plan	Alternate Benefits - 70%/30% Plan
Preventive Health Care Services		
A summary of Covered Preventive Health Care Services is contained in your Certificate of Coverage. Priority Health's complete preventive health care guidelines are available in our Member Center on our website at *priorityhealth.com*, or you may request a copy from our Customer Service department.	Services covered in full. Deductible does not apply.	70% Coverage of reasonable and customary charges. Deductible applies.
Physician's Services		
Primary Care Provider (PCP) Office Visits	100% Coverage. Deductible applies.	70% Coverage of Reasonable and Customary Charges. Deductible applies.
Specialist Office Visit (referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary)	100% Coverage. Deductible applies.	70% Coverage of Reasonable and Customary Charges. Deductible applies.
Routine Pre and Post-natal Care	Services covered in full. No Copayment. Deductible does not apply. (Deductible applies to facility charges for delivery).	70% Coverage of Reasonable and Customary Charges. Deductible applies.
Allergy Care	100% Coverage for injections and serum. Deductible applies.	70% Coverage of Reasonable and Customary Charges. Deductible applies.

Basic Benefits	Preferred Benefits - Plan	Alternate Benefits - 70%/30% Plan
Physician's Services (continued)		
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.	70% Coverage of Reasonable and Customary Charges. Deductible applies.
Rehabilitative Medicine Services		
Physical and Occupational Therapy (includes Spinal Manipulation)	100% Coverage per visit for 30 visits per Contract Year (combined benefit for all therapies listed). Deductible applies.	50% Coverage of reasonable and customary charges up to 30 visits per Contract Year (combined benefit for all therapies listed). Deductible applies.
Speech Therapy	100% Coverage per visit for 30 visits per Contract Year. Deductible applies.	50% Coverage of reasonable and customary charges up to 30 visits per Contract Year. Deductible applies.
Cardiac Rehabilitation and Pulmonary Rehabilitation	100% Coverage per visit for 30 visits per Contract Year (combined benefit for all therapies listed). Deductible applies.	50% Coverage of reasonable and customary charges up to 30 visits per Contract Year (combined benefit for all therapies listed). Deductible applies.
Hospital Services		
Inpatient Services (semi-private room and intensive care, surgery and all related surgical services, ancillary services while inpatient) **Note:** Non-emergency inpatient hospital admissions, other than for normal labor and delivery, must be approved in advance by Priority Health.	100% Coverage. Deductible applies.	70% Coverage of Reasonable and Customary Charges. Pre-approval required or 20% penalty applies. Penalty charges do not apply to out-of-pocket maximums. Deductible applies.
Inpatient Hospital Professional Services	100% Coverage. Deductible applies.	70% Coverage of Reasonable and Customary Charges. Pre-approval required or penalty applies. Penalty charges do not apply to out-of-pocket maximums. Deductible applies.
Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services)	100% Coverage. Prior approval is required for certain radiology examinations. Deductible applies.	70% Coverage of Reasonable and Customary Charges. Pre-approval required or penalty applies. Penalty charges do not apply to out-of-pocket maximums. Deductible applies.
Outpatient Hospital Professional Services	Coverage. Deductible applies.	70% Coverage of Reasonable and Customary Charges. Pre-approval required or penalty applies. Penalty charges do not apply to out-of-pocket maximums. Deductible applies.

Basic Benefits	Preferred Benefits - Plan	Alternate Benefits - 70%/30% Plan
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 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 and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime unless Medically/Clinically necessary to correct or reverse complications from a previous bariatric procedure.*	Physician fees are Covered at 50% of the first $3,000 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 and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime unless Medically/Clinically necessary to correct or reverse complications from a previous bariatric procedure.*
Emergency Medical Care (in or out of the service area)		
Hospital Emergency Room	$50 copayment per visit (waived if admitted) after deductible. Deductible applies.	$50 copayment per visit (waived is admitted) after deductible. Deductible applies.
Urgent Care Center	100% Coverage. Deductible applies.	70% Coverage of reasonable and customary charges. Deductible applies.
Physician's Office	100% Coverage. Deductible applies.	70% Coverage of reasonable and customary charges. Deductible applies.
Ambulance (land or air)	$50 copayment after deductible. Deductible applies.	$50 copayment after deductible. 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 100% Coverage when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.	Not Covered.
Tubal Ligation Professional Fees Outpatient Inpatient	 100% Coverage. Deductible applies. 100% Coverage. Deductible applies. 100% Coverage when performed in connection with delivery or other covered inpatient surgery. Deductible applies.	 Not Covered. Not Covered. Not Covered.
Infertility counseling and treatment of underlying cause of infertility	50% Coverage. Deductible applies.	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	100% Coverage. Maximum 20 days per Contract Year. Deductible applies.	70% Coverage of reasonable and customary charges up to 20 days per Contract Year.
Outpatient Mental Health Services	100% Coverage. Maximum 20 visits per Contract Year. (Two group therapy visits count as one outpatient visit). Deductible applies.	Coverage of reasonable and customary charges per visit up to 20 visits per Contract Year. Deductible applies.
Substance Abuse Services	80% Coverage up to the minimum annual benefit as determined by the State of Michigan per Contract Year. Deductible applies.	70% Coverage of reasonable and customary charges up to the minimum annual benefit as determined by the State of Michigan per Contract Year. Deductible applies.

Other Services	Preferred Benefits - Plan	Alternate Benefits - 70%/30% Plan
Durable Medical Equipment	50% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges. Deductible applies.
Prosthetics & Orthotics	50% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges. Deductible applies.
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	100% Coverage. Maximum 45 days per Contract Year. Deductible applies.	70% Coverage of reasonable and customary charges up to 45 days per Contract Year. Must be prior approved or 20% penalty will apply. Deductible applies.
Home Health Care	100% Coverage. For rehabilitative therapy provided in the home, refer to Rehabilitative Medicine services for Copayment information. Deductible applies.	70% Coverage of reasonable and customary charges. Deductible applies.
Temporomandibular Joint Syndrome (TMJS)	Coverage. Deductible applies.	Coverage of reasonable and customary charges. Deductible applies.
Orthognathic Surgery	Coverage. Deductible applies.	Coverage of reasonable and customary charges. Deductible applies.
Additional Benefits		
Pharmacy Services		
Prescription Drugs **Note:**Prescription drug coverage is based on the usage of a medication formulary. **Covered prescription drugs apply toward Deductibles and Out-of-Pocket Maximums.**	Covered with a $10 Generic / $40 Brand 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 No Rx Deductible. Infertility drugs covered with a 50% Copayment. (Limitations apply) Copayment per prescription after deductible.	Covered with a $10 Generic / $40 Brand 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 No Rx Deductible. Infertility drugs covered with a 50% Copayment. (Limitations apply) after deductible.
Prescription Mail Order	Prescription drugs filled for up to 90 days with a $20 Generic / $80 Brand Copayment per prescription. No Rx Deductible (Limitations apply) Copayment per prescription after deductible.	Prescription drugs filled for up to 90 days with a $20 Generic / $80 Brand Copayment per prescription. No Rx Deductible (Limitations apply)
Eligibility Information		
Dependent Children	Covered until dependent turns age 26.	Covered until dependent turns age 26.

DEPENDENT COVERAGE REQUIRED NOTICE

Individuals whose coverage ended or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26, are eligible to enroll in this plan. Individuals may enroll during the group's next open enrollment period or within 30 days after the group's next renewal.