

PRIORITY HEALTH
priorityhealth.com
PRIORITYPOSSM (POINT OF SERVICE) PRODUCT
HEALTHCARE MIDWEST – PLAN 001
1/1/2010 – 12/31/2010

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
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.	The Deductible is applicable to all covered services except for flat dollar Copayment services. Facility charges for delivery are subject to the Deductible. 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.	The Deductible is applicable to all covered services.
Individual Deductible per Contract Year	\$500	\$1,000
Family Deductible per Contract Year	\$1,000	\$2,000
Note: Services applied to Individual Deductibles will be combined to satisfy the Family Deductible. The Family Deductible is not to exceed the Individual Deductible per person.		

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 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; 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	\$1,500	\$3,000
Family Out-of-Pocket Maximum per Contract Year	\$3,000	\$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
Physician's Services	Deductible applies to all services except where indicated below	Deductible applies to all services
Preventive Health Care Services (face-to-face, telephonic or through secure electronic portal services provided by your PCP 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)	\$0 Copayment	Not Covered
Primary Care Provider (PCP) Office Visit (Includes all office and home visits not considered preventive health care services or routine maternity care services)	\$15 Copayment per visit. Deductible does not apply to PCP visits. Lab or X-ray services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines are covered at 100%. Non-preventive Lab or X-ray services that are not billed by the physician's office are subject to Deductible and Coinsurance.	60% 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 60%.
Specialist Office Visit (referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary)	\$30 Copayment per visit. Deductible does not apply to specialist visits. Lab or X-ray services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines are covered at 100%. Non-preventive Lab or X-ray services that are not billed by the specialist's office are subject to Deductible and Coinsurance.	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	\$15 Copayment per visit. A maximum of four times the office visit Copayment per pregnancy. (Deductible does not apply to routine maternity.)	60% Coverage of reasonable and customary charges
Allergy Care	100% Coverage, after deductible, for injections and serum. Applicable office visit Copayment may apply for testing. Deductible does not apply to office visits.	60% Coverage of reasonable and customary charges

Basic Benefits	Preferred Benefit – 80/20% Plan	Alternate Benefit – 60/40% Plan
Outpatient Services Standard Diagnostic Laboratory and X-Ray Chemotherapy Radiation Therapy Hemodialysis	80% Coverage after deductible 80% Coverage after deductible 80% Coverage after deductible 80% Coverage after deductible	60% Coverage of reasonable and customary charges
Advanced Diagnostic Imaging Includes, but is not limited to the following: (CT, CTA, MRI, MRA, Nuclear Cardiology Studies and PET scanning)	\$150 Copayment per test. Annual maximum of 10 Copayments per individual. (Copayment waived if performed while confined in a Hospital.) Prior approval is required for certain radiology examinations. Deductible does not apply to advanced diagnostic imaging.	60% Coverage of reasonable and customary charges Prior approval is required. Failure to obtain prior approval will result in a 20% reduction in benefits
Rehabilitative Medicine Services		
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation)	\$15 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year. Deductible does not apply.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 30 visits per Contract Year
Speech Therapy	\$15 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year. Deductible does not apply.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 30 visits per Contract Year
Cardiac Rehabilitation and Pulmonary Rehabilitation	\$15 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year. Deductible does not apply.	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 (Including facility-based physician services, radiology examinations and laboratory 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 after deductible	60% Coverage of reasonable and customary charges. Prior approval is required. Failure to obtain prior approval will result in a 20% reduction in benefits. Penalty charges do not apply to out-of-pocket maximums.
Inpatient Hospital Professional Services	80% Coverage after deductible	60% Coverage of reasonable and customary charges. Prior approval is required. Failure to obtain prior approval will result in a 20% reduction in benefits. 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 after deductible Prior approval is required for certain radiology examinations.	60% Coverage of reasonable and customary charges. Prior approval is required. Failure to obtain prior approval will result in a 20% reduction in benefits. Penalty charges do not apply to out-of-pocket maximums
Outpatient Hospital Professional Services	80% Coverage after deductible	60% Coverage of reasonable and customary charges. Prior approval is required. Failure to obtain prior approval will result in a 20% reduction in benefits. Penalty charges do not apply to out-of-pocket maximums

Basic Benefits	Preferred Benefit – 80/20% Plan	Alternate Benefit – 60/40% Plan
<p>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*</p>	<p>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.</p> <p>Deductible applies.</p> <p>*Prior approval required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures.</p>	<p>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.</p> <p>Deductible applies.</p> <p>*Prior approval required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures.</p>
Emergency Medical Care (in or out of the service area)		
Hospital Emergency Room	\$100 Copayment per visit (waived if admitted). Deductible does not apply.	\$100 Copayment per visit (waived if admitted)
Urgent Care Center	\$45 Copayment per visit. Deductible does not apply.	60% Coverage of reasonable and customary charges
Physician's Office	Applicable office visit Copayment applies. Deductible does not apply.	60% Coverage of reasonable and customary charges
Ambulance (land or air)	\$50 Copayment. Deductible does not apply.	\$50 Copayment
Family Planning/Infertility Services (Family Planning and Infertility Services are covered under the Preferred Benefit only.)		
Vasectomy	100% Coverage, after deductible, when performed in a provider's office or 80% Coverage, after deductible, when performed in connection with other covered inpatient or outpatient surgery.	Not Covered (including physician's fees and any other related charges)
Tubal Ligation		
Professional Fees	80% Coverage after deductible	Not Covered (including physician's fees and any other related charges)
Outpatient	80% Coverage after deductible	Not Covered (including physician's fees and any other related charges)
Inpatient	80% Coverage, after deductible, when performed in connection with delivery or other covered inpatient surgery.	Not Covered (including physician's fees and any other related charges)
Infertility Services for diagnostic, counseling and planning services for treatment of the underlying cause of infertility	50% Coverage after deductible. Prescription drugs for infertility treatment covered only with prescription drug rider.	Not Covered (including physician's fees and any other related charges)

Basic Benefits	Preferred Benefit – 80/20% Plan	Alternate Benefit –60/40% Plan
Behavioral Health 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)	80% Coverage after deductible.	60% Coverage of reasonable and customary charges Failure to obtain prior approval will result in a 20% reduction of benefits.
Outpatient Mental Health & Substance Abuse Services (including medication management)	\$15 Copayment MSW & Psychologist. \$30 Copayment Psychiatrist, including med management Deductible does not apply.	60% Coverage of reasonable and customary charges per visit
Other Services		
Dietitian Services	\$30 Copayment per visit. Up to six visits per Contract Year.	Not Covered (including physician's fees and any other related charges)
Durable Medical Equipment	80% Coverage after deductible	50% Coverage of reasonable and customary charges
Prosthetics & Orthotics	80% Coverage after deductible	50% Coverage of reasonable and customary charges
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	80% Coverage, after deductible. Maximum 45 days per Contract Year.	60% Coverage of reasonable and customary charges up to 45 days per Contract Year. Prior approval is required. Failure to obtain prior approval will result in a 20% reduction in benefits.
Home Health Care (including Hospice Services, excluding Rehabilitative Medicine)	Covered in full after deductible.	60% Coverage of reasonable and customary charges
Temporomandibular Joint Syndrome (TMJS)	50% Coverage after deductible	50% Coverage of reasonable and customary charges
Orthognathic Surgery	50% Coverage after deductible	50% Coverage of reasonable and customary charges

Note: Reasonable and Customary Charges – Alternate Benefit: Your Alternate Benefits will be calculated using the lower billed charges or Reasonable and Customary Charges for such service(s). See your Certificate of Coverage (COC) for details.

Additional Benefits		
Pharmacy Services		
Prescription Drugs Note: Prescription drug coverage is based on the usage of medication formulary.	Tier 1- Generic Drugs \$10 Copay per prescription or refill for a Generic Drug Tier 2- Preferred Brand-Name Drugs \$50 Copay per prescription or refill for a Preferred Brand-Name Drug Infertility Treatment 50% Copay for drugs used for treating infertility. (Limitations apply) 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 \$50 Copay per prescription or refill for a Preferred Brand-Name Drug Infertility Treatment 50% Copay for drugs used for treating infertility. (Limitations apply) 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.
Prescription Mail Order	Tier 1- Generic Drugs \$20 Copay per prescription or refill for a Generic Drug Tier 2- Preferred Brand-Name Drugs \$100 Copay per prescription or refill for a Preferred Brand-Name Drug 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 \$100 Copay per prescription or refill for a Preferred Brand-Name Drug Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply)
Basic Benefits	Preferred Benefit – 80/20% Plan	Alternate Benefit – 60/40% Plan
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

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