

PRIORITY HEALTH
priorityhealth.com
PRIORITYHSASM POINT OF SERVICE (POS) PRODUCT
CLIMAX-SCOTTS COMMUNITY SCHOOLS
11/1/2010 – 8/31/2011

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
<p>The Deductible is the amount of Covered Services you must incur during the Contract Year before benefits will be paid. The Deductible is combined for Preferred Benefits and Alternate Benefits. You must meet the Deductible before benefits will be paid for services you seek under either the Preferred or Alternate Benefits.</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 (<u>denied as non-Covered Services</u>) and <u>penalties paid for failure to preauthorize services</u>.</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>		
<p>Individual Deductible per Contract Year</p>	<p>\$1,500</p>	
<p>Family Deductible per Contract Year</p>	<p>\$3,000</p>	

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>The amounts calculated towards the Preferred Benefits Out-of-Pocket Maximums apply to the amounts calculated towards the Alternate Benefits Out-of-Pocket Maximums.</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>The amounts calculated towards the Alternate Benefits Out-of-Pocket Maximums apply to the amounts calculated towards the Preferred Benefits Out-of-Pocket Maximums.</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	\$3,000	\$4,500
Family Out-of-Pocket Maximum per Contract Year	\$6,000	\$9,000
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, \$0 Preventive Care Copayment. Deductible applies.	80% Coverage for face to face visits only. 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		80% Coverage. Deductible applies.
Diagnostic Laboratory and X-Ray	100% Coverage. Deductible applies.	
Chemotherapy	100% Coverage. Deductible applies.	
Radiation Therapy	100% Coverage. Deductible applies.	
Hemodialysis	100% Coverage. Deductible applies.	
Rehabilitative Medicine Services		
Physical and Occupational Therapy (including osteopathic and chiropractic 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 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%, 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 (including Physicians' fees and any other charges)
Tubal Ligation		
Professional Fees	100% Coverage. Deductible applies.	Not Covered (including Physicians' fees and any other charges)
Outpatient	100% Coverage. Deductible applies.	Not Covered (including Physicians' fees and any other charges)
Inpatient	100% Coverage when performed in connection with delivery or other covered inpatient surgery. Deductible applies.	Not Covered (including Physicians' fees and any other charges)
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 (including Physicians' fees and any other charges)
Behavioral Health Services		
Contact Priority Health's Behavioral Health Department at 616 464-8500 or 800 673-8043 if you have questions about your Mental Health or Substance Abuse benefits or coverage.		
Inpatient Mental Health and Substance Abuse Services (including rehabilitation and partial hospitalization) Non-emergency inpatient admissions must be approved in advance by Priority Health.	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.
Behavioral Health Services (continued)		
Outpatient Mental Health and 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 (including Hospice services, excluding Rehabilitative Medicine)	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	Deductible Applies	
Prescription Drugs Note: Prescription drug coverage is based on the usage of a medication formulary. CM INCLUDED: 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.	100% Coverage. Deductible applies.	Preferred Benefit Only
Prescription Mail Order Filled for up to 90 days CM INCLUDED: Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply)	Prescription drugs filled for up to 90 days Covered at 100%. Deductible applies	Preferred Benefit Only
Eligibility Information		
Dependent Children	Covered until dependent reaches age 26, regardless of student status.	Covered until dependent reaches age 26, regardless of student status.
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

9/13/2010 CMS



ADN Administrators, Inc.
 PO Box 610
 Southfield, MI 48037
 248-901-3705

CLIMAX-SCOTTS COMMUNITY SCHOOLS Dental Benefits Plan
Administrators, Teachers and Support Staff

The Plan-at-a-Glance **PPO Networks: ADN Dental Network, Michigan Dental Plan, DenteMax**

Maximum Benefits **Plan year September 1 through August 31**

Annual Maximum \$1000 per eligible individual for covered class I, II and III services.
 Lifetime Maximum \$ 600 per eligible individual for covered class IV services

Class I Preventive Services – 60%

Oral Examinations	Twice per plan year
Bitewing X-Rays	Once per plan year
Prophylaxis (Cleaning)	Twice per plan year (including Periodontal Maintenance)
Topical Application of Fluoride	Twice per plan year to age 19
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Space Maintainers	Once per area per lifetime, up to age 14

Class II Restorative Services – 60%

Composite and Amalgam fillings	Once per tooth surface per 24 months
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year following treatment (including Prophylaxes)
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Onlays and Crowns**	Once per permanent tooth in 60 months
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch

Class III Major Services – 60%

Complete and Partial Removable Dentures**	Once per arch per 60 months
Fixed Partial Dentures (Bridges)**	Once per arch per 60 months
Endosteal Implants	Once per permanent tooth per 60 months
Addition of Teeth to Partial Dentures	

Class IV Orthodontic Services – 60%

Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19

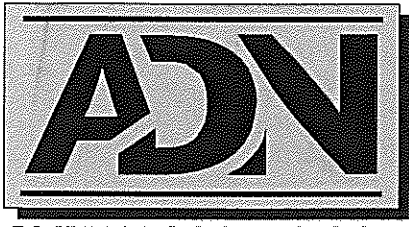
Not Covered

Sealants	Cosmetic Treatment
Epoosteal and Transosteal implants	
TMJ/TMD Treatment	

Deductible – None
 Missing Tooth Clause – None
 12 Month Billing Limitation
 Waiting Periods – None
 COB – Standard

**Composite, porcelain and ceramic not covered for posterior teeth, alternate benefit applies
 **Prosthetics are considered on delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding \$200.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**



CLIMAX-SCOTTS COMMUNITY SCHOOLS - Vision Benefits Plan

Administered by ADN Administrators, Inc.

The Plan-at-a-Glance

Benefit Year – September 1 through August 31

Vision Examination

Covered at 100% of Reasonable & Customary (R&C)
following \$6.50 Deductible

Spectacle Lenses (Pair):

Single Vision

Covered at 100% of R&C

Bifocal

following \$9 Deductible

Trifocal

According to Limits & Exclusions

Lenticular

Frames

Covered Up to \$65
following \$9 Deductible

Contact Lenses (Pair)

Medically Necessary

Covered at 100% of R&C

*Cosmetic/Elective (Includes Vision Exam and Fitting)

Covered Up to \$90

*Disposable (Includes Vision Exam and Fitting)

Covered Up to \$90

Extra Lens Features – Tinted, Transition, Rimless, Oversize, Polarized and Blended Lenses

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or contact lenses, but not both

No Payments will be made for the following:

1. Non-corrective lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Charges for cosmetic (elective) contact lenses, including the exam, prescription and fitting fee, that exceed the plan allowance

Note: For each benefit year, covered charges for contact lenses are in lieu of all other covered charges during the benefit year for each insured person.