SET SEG

Medical Rate Summary

West Branch-Rose City Area Schools

All Employees

Assumed Effective Date: 9/1/2011

Current Plan(s) and Segment:		1P	2P	FF	Admin/ Deductible Funding	Composite	Total Cost
Teachers, Administrators, and Support Staff with Choices II	**Census**	19	37	77			
MESSA Choices II $10/$20	**Rate**	$628.52	$1,412.29	$1,569.04		$1,391	$2,220,152
Teachers, Administrators, and Support Staff with Supercare	**Census**		1	2			
MESSA Supercare	**Rate**	$765.28	$1,719.99	$1,910.94		$1,847	$66,502
Steelworkers	**Census**	9	35	29			
BCBSM Community Blue 2 $10/$20 Rx	**Rate**	$614.78	$1,475.45	$1,844.32		$1,516	$1,327,909
	TOTALS:	28	73	108	**209**	$1,441	**$3,614,563**

	Equivalent Rates (Including Deductible Funding and Fees as Applicable)					Estimated	Worst Case
Product Name	**1P**	**2P**	**FF**	**Composite**	**Total Cost**	**Annual Savings**	**Exposure**
EHIM SMRP Self-funded Rx							
BCBSM/EHIM FB2 to First Dollar SF $10/$20 Rx	$466	$1,117	$1,436	$1,195	$2,995,973	$618,590	$3,215,348
BCBSM/EHIM FB2 to First Dollar SF $10/$30 Rx	$463	$1,111	$1,427	$1,187	$2,978,152	$636,412	$3,197,527
BCBSM/EHIM FB2 to First Dollar SF $10/$40 Rx	$460	$1,105	$1,418	$1,180	$2,960,594	$653,969	$3,179,969
BCBSM/EHIM FB2 to First Dollar SF $10/$60 Rx	$456	$1,093	$1,401	$1,167	$2,926,995	$687,568	$3,146,370
BCBSM/EHIM FB2 to First Dollar SF $10/$20/$40 Rx	$465	$1,115	$1,432	$1,192	$2,988,658	$625,905	$3,208,033
BCBSM/EHIM FB3 to First Dollar SF $10/$20 Rx	$441	$1,058	$1,363	$1,133	$2,841,621	$772,942	$3,270,621
BCBSM/EHIM FB3 to First Dollar; $100/$200 ded; SF $10/$20 Rx	$438	$1,051	$1,355	$1,126	$2,824,071	$790,492	$3,231,621
BCBSM/EHIM FB3 to First Dollar; $200/$400 ded; SF $10/$20 Rx	$435	$1,045	$1,346	$1,119	$2,806,521	$808,042	$3,192,621
BCBSM/EHIM FB3 to First Dollar SF $10/$30 Rx	$438	$1,052	$1,354	$1,126	$2,823,800	$790,764	$3,252,800
BCBSM/EHIM FB3 to First Dollar SF; $200/$400 Ded; $10/$30 Rx	$433	$1,039	$1,337	$1,112	$2,788,700	$825,864	$3,174,800
BCBSM/EHIM FB3 to First Dollar SF $10/$40 Rx	$436	$1,046	$1,346	$1,119	$2,806,242	$808,321	$3,235,242
BCBSM/EHIM FB3 to First Dollar SF; $200/$400 Ded; $10/$40 Rx	$430	$1,033	$1,329	$1,105	$2,771,142	$843,421	$3,157,242
BCBSM/EHIM FB3 to First Dollar SF $10/$60 Rx	$431	$1,034	$1,329	$1,106	$2,772,643	$841,920	$3,201,643
BCBSM/EHIM FB3 to First Dollar SF $10/$20/$40 Rx	$440	$1,055	$1,360	$1,130	$2,834,306	$780,258	$3,263,306
BCBSM/EHIM FB2 to School Plan II SF $10/$20 Rx	$475	$1,141	$1,466	$1,220	$3,058,673	$555,890	$3,278,048
BCBSM/EHIM FB2 to School Plan II SF $10/$30 Rx	$473	$1,135	$1,457	$1,212	$3,040,852	$573,712	$3,260,227
BCBSM/EHIM FB2 to School Plan II SF $10/$40 Rx	$470	$1,128	$1,448	$1,205	$3,023,294	$591,269	$3,242,669
BCBSM/EHIM FB2 to School Plan II SF $10/$60 Rx	$465	$1,117	$1,431	$1,192	$2,989,695	$624,868	$3,209,070
BCBSM/EHIM FB2 to School Plan II SF $10/$20/$40 Rx	$474	$1,138	$1,462	$1,217	$3,051,358	$563,205	$3,270,733
BCBSM/EHIM FB3 to School Plan II SF $10/$20 Rx	$451	$1,081	$1,393	$1,158	$2,904,321	$710,242	$3,333,321
BCBSM/EHIM FB3 to School Plan II; $100/$200 ded; SF $10/$20 Rx	$448	$1,075	$1,385	$1,151	$2,886,771	$727,792	$3,294,321
BCBSM/EHIM FB3 to School Plan II SF $10/$30 Rx	$448	$1,075	$1,384	$1,151	$2,886,500	$728,064	$3,315,500
BCBSM/EHIM FB3 to School Plan II SF $10/$40 Rx	$445	$1,069	$1,376	$1,144	$2,868,942	$745,621	$3,297,942
BCBSM/EHIM FB3 to School Plan II SF $10/$60 Rx	$441	$1,057	$1,359	$1,131	$2,835,343	$779,220	$3,264,343
BCBSM/EHIM FB3 to School Plan II SF $10/$20/$40 Rx	$450	$1,079	$1,390	$1,155	$2,897,006	$717,558	$3,326,006
EHIM CB SMRP w BCBSM Rx							

Product Name	Equivalent Rates (Including Deductible Funding and Fees as Applicable) 1P	2P	FF	Composite	Total Cost	Estimated Annual Savings	Worst Case Exposure
BCBSM/EHIM CB15-20 to First Dollar Insured $10/$20 Rx	$616	$1,479	$1,849	$1,555	$3,899,680	-$285,117	$5,167,180
BCBSM/EHIM CB15-20 to First Dollar Insured $10/$60 Rx	$492	$1,180	$1,475	$1,240	$3,109,927	$504,636	$4,377,427
BCBSM/EHIM CB15-0 to School Plan II Insured $10/$60 Rx	$524	$1,257	$1,571	$1,321	$3,313,589	$300,975	$3,752,339
BCBSM/EHIM CB15-20 to School Plan II Insured $10/$20 Rx	$626	$1,503	$1,879	$1,580	$3,962,380	-$347,817	$5,229,880
BCBSM/EHIM CB15-20 to School Plan II Insured $10/$60 Rx	$501	$1,204	$1,504	$1,265	$3,172,627	$441,936	$4,440,127
EHIM CB SMRP w SMRP Rx							
BCBSM/EHIM CB15-0 to School Plan II BCBSM Rx $10/$60 to $0/$0	$562	$1,349	$1,686	$1,417	$3,554,984	$59,580	$3,993,734
BCBSM/EHIM CB15-0 to School Plan II BCBSM Rx $10/$60 to $0/$20	$551	$1,322	$1,653	$1,390	$3,486,014	$128,550	$3,924,764
BCBSM/EHIM CB15-0 to CB1 BCBSM Rx $10/$60 to $0/$0	$552	$1,325	$1,656	$1,392	$3,492,284	$122,280	$3,931,034
BCBSM/EHIM CB15-0 to CB1 BCBSM Rx $10/$60 to $0/$20	$541	$1,299	$1,623	$1,365	$3,423,314	$191,250	$3,862,064
BCBSM/EHIM CB15-20 to School Plan II BCBSM Rx $10/$60 to $0/$0	$540	$1,295	$1,619	$1,361	$3,414,022	$200,541	$4,681,522
BCBSM/EHIM CB15-20 to School Plan II BCBSM Rx $10/$60 to $0/$20	$529	$1,269	$1,586	$1,334	$3,345,052	$269,511	$4,612,552
BCBSM/EHIM CB15-20 to CB1 BCBSM Rx $10/$60 to $0/$0	$530	$1,271	$1,589	$1,336	$3,351,322	$263,241	$4,618,822
BCBSM/EHIM CB15-20 to CB1 BCBSM Rx $10/$60 to $0/$20	$519	$1,245	$1,557	$1,309	$3,282,352	$332,211	$4,549,852
BCBSM HRA Simply Blue Plans to First Dollar; SF Rx							
BCBSM/EHIM SB HRA 1000 to First Dollar; $10/$20 SF Rx	$546	$1,311	$1,686	$1,402	$3,516,552	$98,012	$4,062,552
BCBSM/EHIM SB HRA 1000 to First Dollar; $10/$30 SF Rx	$544	$1,305	$1,677	$1,395	$3,498,730	$115,833	$4,044,730
BCBSM/EHIM SB HRA 1000 to First Dollar; $10/$40 SF Rx	$541	$1,299	$1,668	$1,388	$3,481,173	$133,391	$4,027,173
BCBSM/EHIM SB HRA 1000 to First Dollar; $10/$60 SF Rx	$536	$1,287	$1,651	$1,375	$3,447,573	$166,990	$3,993,573
BCBSM/EHIM SB HRA 1000 to First Dollar; $10/$20/$40 SF Rx	$545	$1,308	$1,682	$1,399	$3,509,236	$105,327	$4,055,236
BCBSM/EHIM SB HRA 1500 to First Dollar; $10/$20 SF Rx	$534	$1,281	$1,649	$1,371	$3,438,475	$176,088	$4,140,475
BCBSM/EHIM SB HRA 1500 to First Dollar; $10/$30 SF Rx	$531	$1,274	$1,640	$1,364	$3,420,654	$193,910	$4,122,654
BCBSM/EHIM SB HRA 1500 to First Dollar; $10/$40 SF Rx	$529	$1,268	$1,631	$1,357	$3,403,096	$211,467	$4,105,096
BCBSM/EHIM SB HRA 1500 to First Dollar; $10/$60 SF Rx	$524	$1,257	$1,615	$1,343	$3,369,497	$245,066	$4,071,497
BCBSM/EHIM SB HRA 1500 to First Dollar; $10/$20/$40 SF Rx	$533	$1,278	$1,646	$1,368	$3,431,160	$183,403	$4,133,160
BCBSM/EHIM SB HRA 2500 to First Dollar; $10/$20 SF Rx	$511	$1,227	$1,586	$1,317	$3,302,654	$311,909	$4,277,654
BCBSM/EHIM SB HRA 2500 to First Dollar; $10/$30 SF Rx	$509	$1,221	$1,577	$1,310	$3,284,833	$329,731	$4,259,833
BCBSM/EHIM SB HRA 2500 to First Dollar; $10/$40 SF Rx	$506	$1,215	$1,568	$1,303	$3,267,275	$347,288	$4,242,275
BCBSM/EHIM SB HRA 2500 to First Dollar; $10/$60 SF Rx	$502	$1,204	$1,551	$1,289	$3,233,676	$380,887	$4,208,676
BCBSM/EHIM SB HRA 2500 to First Dollar; $10/$20/$40 SF Rx	$510	$1,225	$1,582	$1,314	$3,295,339	$319,224	$4,270,339
BCBSM/EHIM SB HRA 2500 to First Dollar; $100/$200; $10/$20 SF Rx	$508	$1,220	$1,577	$1,309	$3,283,154	$331,409	$4,238,654
BCBSM/EHIM SB HRA 2500 to First Dollar; $200/$400; $10/$20 SF Rx	$505	$1,213	$1,567	$1,301	$3,263,654	$350,909	$4,199,654
BCBSM/EHIM SB HRA 4000 to First Dollar; $10/$20 SF Rx	$475	$1,141	$1,481	$1,227	$3,078,266	$536,297	$4,599,266
BCBSM/EHIM SB HRA 4000 to First Dollar; $10/$30 SF Rx	$473	$1,135	$1,472	$1,220	$3,060,445	$554,119	$4,581,445
BCBSM/EHIM SB HRA 4000 to First Dollar; $10/$40 SF Rx	$470	$1,129	$1,463	$1,213	$3,042,887	$571,676	$4,563,887
BCBSM/EHIM SB HRA 4000 to First Dollar; $10/$60 SF Rx	$466	$1,117	$1,446	$1,200	$3,009,288	$605,275	$4,530,288
BCBSM/EHIM SB HRA 4000 to First Dollar; $10/$20/$40 SF Rx	$474	$1,138	$1,477	$1,224	$3,070,951	$543,612	$4,591,951
BCBSM/EHIM SB HRA 4000 to First Dollar; $100/$200 Ded; $10/$20 SF Rx	$473	$1,135	$1,473	$1,221	$3,062,666	$551,897	$4,560,266
BCBSM/EHIM SB HRA 4000 to First Dollar; $100/$200 Ded; $10/$40 SF Rx	$468	$1,123	$1,456	$1,207	$3,027,287	$587,276	$4,524,887
BCBSM/EHIM SB HRA 4000 to First Dollar; $200/$400 Ded; $10/$20 SF Rx	$471	$1,129	$1,466	$1,215	$3,047,066	$567,497	$4,521,266
BCBSM HRA Simply Blue Plans to School Plan II; SF Rx							
BCBSM/EHIM SB HRA 1000 to School Plan II; $10/$20 SF Rx	$552	$1,325	$1,704	$1,417	$3,554,172	$60,392	$4,100,172
BCBSM/EHIM SB HRA 1000 to School Plan II; $10/$30 SF Rx	$549	$1,319	$1,695	$1,410	$3,536,350	$78,213	$4,082,350
BCBSM/EHIM SB HRA 1000 to School Plan II; $10/$40 SF Rx	$547	$1,313	$1,686	$1,403	$3,518,793	$95,771	$4,064,793
BCBSM/EHIM SB HRA 1000 to School Plan II; $10/$60 SF Rx	$542	$1,301	$1,669	$1,390	$3,485,193	$129,370	$4,031,193

Product Name	Equivalent Rates (Including Deductible Funding and Fees as Applicable) 1P	2P	FF	Composite	Total Cost	Estimated Annual Savings	Worst Case Exposure
BCBSM/EHIM SB HRA 1000 to School Plan II; $10/$20/$40 SF Rx	$551	$1,322	$1,700	$1,414	$3,546,856	$67,707	$4,092,856
BCBSM/EHIM SB HRA 1500 to School Plan II; $10/$20 SF Rx	$539	$1,295	$1,667	$1,386	$3,476,095	$138,468	$4,178,095
BCBSM/EHIM SB HRA 1500 to School Plan II; $10/$30 SF Rx	$537	$1,288	$1,658	$1,379	$3,458,274	$156,290	$4,160,274
BCBSM/EHIM SB HRA 1500 to School Plan II; $10/$40 SF Rx	$534	$1,282	$1,650	$1,372	$3,440,716	$173,847	$4,142,716
BCBSM/EHIM SB HRA 1500 to School Plan II; $10/$60 SF Rx	$530	$1,271	$1,633	$1,358	$3,407,117	$207,446	$4,109,117
BCBSM/EHIM SB HRA 1500 to School Plan II; $10/$20/$40 SF Rx	$538	$1,292	$1,664	$1,383	$3,468,780	$145,783	$4,170,780
BCBSM/EHIM SB HRA 2500 to School Plan II; $10/$20 SF Rx	$517	$1,241	$1,604	$1,332	$3,340,274	$274,289	$4,315,274
BCBSM/EHIM SB HRA 2500 to School Plan II; $10/$30 SF Rx	$515	$1,235	$1,595	$1,325	$3,322,453	$292,111	$4,297,453
BCBSM/EHIM SB HRA 2500 to School Plan II; $10/$40 SF Rx	$512	$1,229	$1,586	$1,318	$3,304,895	$309,668	$4,279,895
BCBSM/EHIM SB HRA 2500 to School Plan II; $10/$60 SF Rx	$507	$1,218	$1,569	$1,304	$3,271,296	$343,267	$4,246,296
BCBSM/EHIM SB HRA 2500 to School Plan II; $10/$20/$40 SF Rx	$516	$1,239	$1,601	$1,329	$3,332,959	$281,604	$4,307,959
BCBSM/EHIM SB HRA 2500 to School Plan II; $100/$200 Ded; $10/$20 SF Rx	$514	$1,234	$1,595	$1,324	$3,320,774	$293,789	$4,276,274
BCBSM/EHIM SB HRA 4000 to School Plan II; $10/$20 SF Rx	$481	$1,155	$1,499	$1,242	$3,115,886	$498,677	$4,636,886
BCBSM/EHIM SB HRA 4000 to School Plan II; $10/$40 SF Rx	$476	$1,143	$1,481	$1,228	$3,080,507	$534,056	$4,601,507
BCBSM/EHIM SB HRA 4000 to School Plan II; $10/$60 SF Rx	$471	$1,131	$1,464	$1,215	$3,046,908	$567,655	$4,567,908
BCBSM/EHIM SB HRA 4000 to School Plan II; $10/$20/$40 SF Rx	$480	$1,152	$1,495	$1,239	$3,108,571	$505,992	$4,629,571
BCBSM/EHIM SB HRA 4000 to School Plan II; $100/$200; $10/$20 SF Rx	$479	$1,149	$1,492	$1,236	$3,100,286	$514,277	$4,597,886
BCBSM/EHIM SB HRA 4000 to School Plan II; $100/$200; $10/$40 SF Rx	$474	$1,137	$1,474	$1,222	$3,064,907	$549,656	$4,562,507
BCBSM HRA Simply Blue Plans to First Dollar							
BCBSM/EHIM SB HRA 1500 to First Dollar; $5/$25/$50 Rx	$576	$1,382	$1,728	$1,453	$3,643,034	-$28,470	$4,345,034
BCBSM/EHIM SB HRA 1500 to First Dollar; $100/$200 Ded; $5/$25/$50 Rx	$572	$1,374	$1,717	$1,444	$3,621,584	-$7,020	$4,306,034
BCBSM/EHIM SB HRA 2500 to First Dollar; $5/$25/$50 Rx	$554	$1,330	$1,663	$1,398	$3,507,204	$107,360	$4,482,204
BCBSM/EHIM SB HRA 4000 to First Dollar; $5/$25/$50 Rx	$519	$1,245	$1,557	$1,309	$3,282,837	$331,726	$4,803,837
BCBSM/EHIM SB HRA 4000 to First Dollar; $100/$200 Ded; $5/$25/$50 Rx	$516	$1,239	$1,549	$1,303	$3,267,237	$347,326	$4,764,837
BCBSM HRA Simply Blue Plans to School Plan II							
BCBSM/EHIM SB HRA 1000 to School Plan II; $5/$25/$50 Rx	$594	$1,426	$1,782	$1,499	$3,758,752	-$144,188	$4,304,752
BCBSM/EHIM SB HRA 1500 to School Plan II; $5/$25/$50 Rx	$582	$1,396	$1,745	$1,468	$3,680,654	-$66,090	$4,382,654
BCBSM/EHIM SB HRA 1500 to School Plan II; $100/$200 Ded; $5/$25/$50 Rx	$578	$1,388	$1,735	$1,459	$3,659,204	-$44,640	$4,343,654
BCBSM/EHIM SB HRA 2500 to School Plan II; $5/$25/$50 Rx	$560	$1,345	$1,681	$1,413	$3,544,824	$69,740	$4,519,824
BCBSM/EHIM SB HRA 4000 to School Plan II; $5/$25/$50 Rx	$525	$1,260	$1,575	$1,324	$3,320,457	$294,106	$4,841,457
BCBSM/EHIM SB HRA 4000 to School Plan II; $100/$200 Ded; $5/$25/$50 Rx	$522	$1,254	$1,567	$1,318	$3,304,857	$309,706	$4,802,457
BCBSM HRA Simply Blue Plans to CB Plan							
BCBSM/EHIM SB HRA 1000 to CB 1; $5/$25/$50 Rx	$594	$1,426	$1,782	$1,499	$3,758,752	-$144,188	$4,304,752
BCBSM/EHIM SB HRA 1500 to CB 1; $5/$25/$50 Rx	$582	$1,396	$1,745	$1,468	$3,680,654	-$66,090	$4,382,654
BCBSM/EHIM SB HRA 2500 to CB 1; $5/$25/$50 Rx	$560	$1,345	$1,681	$1,413	$3,544,824	$69,740	$4,519,824
BCBSM/EHIM SB HRA 4000 to CB 1; $5/$25/$50 Rx	$525	$1,260	$1,575	$1,324	$3,320,457	$294,106	$4,841,457
BCBSM/EHIM SB HRA 4000 to CB 2; $5/$25/$50 Rx	$522	$1,254	$1,567	$1,318	$3,304,857	$309,706	$4,802,457
BCBSM HRA Simply Blue Plans (Partially Paid Deductible)							
BCBSM/EHIM SB HRA $1,000; $5/$25/$50 Rx (50% Funded)	$482	$1,156	$1,445	$1,215	$3,046,972	$567,592	$3,241,972
BCBSM/EHIM SB HRA $1,500; $5/$25/$50 Rx (50% Funded)	$479	$1,148	$1,436	$1,207	$3,027,374	$587,190	$3,319,874
BCBSM/EHIM SB HRA $2,500; $5/$25/$50 Rx (50% Funded)	$469	$1,127	$1,408	$1,184	$2,969,544	$645,020	$3,457,044
BCBSM/EHIM SB HRA $4,000; $5/$25/$50 Rx (50% Funded)	$474	$1,138	$1,422	$1,196	$2,998,677	$615,886	$3,778,677
BCBSM Simply Blue HSA Plans							
BCBSM SB HSA 1250-0%; $5/$25/$50 Rx	$464	$1,113	$1,391	$1,170	$2,934,150	$680,413	$2,934,150
BCBSM SB HSA 1250-0%; $100/$200 Ded; $5/$25/$50 Rx	$458	$1,098	$1,373	$1,154	$2,895,150	$719,413	$2,895,150
BCBSM SB HSA 1250-0%; $200/$400 Ded; $5/$25/$50 Rx	$451	$1,084	$1,354	$1,139	$2,856,150	$758,413	$2,856,150
BCBSM SB HSA 1250-20%; $5/$25/$50 Rx	$423	$1,015	$1,269	$1,067	$2,676,153	$938,411	$2,676,153
BCBSM SB HSA 2000-0%; $5/$25/$50 Rx	$464	$1,114	$1,392	$1,170	$2,935,282	$679,282	$2,935,282

Product Name	Equivalent Rates (Including Deductible Funding and Fees as Applicable) 1P	2P	FF	Composite	Total Cost	Estimated Annual Savings	Worst Case Exposure
BCBSM SB HSA 3000-0%; $5/$25/$50 Rx	$465	$1,117	$1,396	$1,174	$2,943,170	$671,393	$2,943,170
BCBSM SB HSA 3000-0%; $100/$200 Ded; $5/$25/$50 Rx	$459	$1,102	$1,377	$1,158	$2,904,170	$710,393	$2,904,170
BCBSM SB HSA 3000-20%; $5/$25/$50 Rx	$440	$1,055	$1,319	$1,109	$2,780,761	$833,802	$2,780,761
BCBSM HSA Simply Blue Plans (Partially Paid Deductible)							
BCBSM SB HSA 1250-0%; $5/$25/$50 Rx (75% Funded)	$445	$1,067	$1,334	$1,121	$2,812,275	$802,288	$2,934,150
BCBSM SB HSA 1250-0%; $5/$25/$50 Rx (50% Funded)	$425	$1,021	$1,276	$1,073	$2,690,400	$924,163	$2,934,150
BCBSM SB HSA 1250-0%; $5/$25/$50 Rx (25% Funded)	$406	$974	$1,218	$1,024	$2,568,525	$1,046,038	$2,934,150
BCBSM SB HSA 1250-0%; $5/$25/$50 Rx (0% Funded)	$387	$928	$1,160	$976	$2,446,650	$1,167,913	$2,934,150
BCBSM SB HSA 3000-0%; $5/$25/$50 Rx (75% Funded)	$419	$1,006	$1,257	$1,057	$2,650,670	$963,893	$2,943,170
BCBSM SB HSA 3000-0%; $5/$25/$50 Rx (50% Funded)	$373	$895	$1,118	$940	$2,358,170	$1,256,393	$2,943,170
BCBSM SB HSA 3000-0%; $5/$25/$50 Rx (25% Funded)	$327	$784	$980	$824	$2,065,670	$1,548,893	$2,943,170
BCBSM SB HSA 3000-0%; $5/$25/$50 Rx (0% Funded)	$280	$673	$841	$707	$1,773,170	$1,841,393	$2,943,170
Priority Health Conventional POS Plans							
Priority Health POS 3; $20 OV; $250/$500 Ded; $10/$40/$80 Rx with specialty	$449	$1,009	$1,121	$992	$2,486,738	$1,127,826	$2,584,238
Priority Health POS 3; $20 OV; $500/$1,000 Ded; $10/$40/$80 Rx with specialty	$436	$979	$1,088	$962	$2,413,861	$1,200,703	$2,608,861
Priority Health Conventional PPO Plans							
Priority Health PPO 3; $20 OV; $500/$1,000 Ded; $10/$40/$80 Rx with specialty	$455	$1,023	$1,137	$1,006	$2,522,780	$1,091,783	$2,717,780
Priority Health POS HSA Plans							
Priority Health POS HSA Mid Plan $10/$40 Rx	$558	$1,254	$1,393	$1,232	$3,090,611	$523,953	$3,090,611
Priority Health POS HSA Min Plan $10/$40 Rx	$546	$1,228	$1,364	$1,207	$3,026,652	$587,911	$3,026,652
Priority Health PPO HSA Plans							
Priority Health PPO HSA Mid Plan $10/$40 Rx	$595	$1,336	$1,484	$1,313	$3,293,690	$320,873	$3,293,690
Priority Health PPO HSA Mid Plan-90%; $10/$40 Rx	$637	$1,432	$1,590	$1,407	$3,529,410	$85,153	$3,529,410
BCN Plan 10							
BCN Plan 10; $20 OV; $10/$20 Rx	$454	$1,043	$1,248	$1,070	$2,683,166	$931,397	$2,683,166

***Stated utilization rates are estimates and will be revisited after program utilization analysis can be obtained under the new program offerings**

***If transitioning from another TPA, run-in claim administration will have a $5.00 pepm for first three months and $10.00 per claim thereafter**

SET SEG

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

Medical Plan Comparison

West Branch-Rose City Area Schools

All Employees

	CURRENT PLAN Teachers, Administrators, and Support Staff with Choices II		CURRENT PLAN Teachers, Administrators, and Support Staff with Supercare		CURRENT PLAN Steelworkers		Priority Health POS 3; $20 OV; $250/$500 Ded; $10/$40/$80 Rx with specialty		Priority Health POS 3; $20 OV; $500/$1,000 Ded; $10/$40/$80 Rx with specialty		Priority Health PPO 3; $20 OV; $500/$1,000 Ded; $10/$40/$80 Rx with specialty	
Carrier	MESSA Choices II $10/$20		MESSA Supercare		BCBSM Community Blue 2 $10/$20 Rx		Priority Health		Priority Health		Priority Health	
Rate Period	7/1/2011 - 6/30/2012		7/1/2011 - 6/30/2012		7/1/2011 - 6/30/2012		9/1/2011 - 8/31/2012		9/1/2011 - 8/31/2012		9/1/2011 - 8/31/2012	
Purchased Plan Features	In Network		In Network		In Network		In Network		In Network		In Network	
Coinsurance	0%		10%		0%		0%		0%		0%	
Deductible Individual	$100		$50		$100		$250		$500		$500	
Deductible Family	$200		$100		$200		$500		$1,000		$1,000	
Post-Deductible Coinsurance - Individual	$0		$0		$500		$0		$0		$0	
Post-Deductible Coinsurance - Family	$0		$0		$1,000		$0		$0		$0	
Office Visit Copay	$10		n/a		$20		$20		$20		$20	
Rx Copay	$10/$20		$10/$20		$10/$20		$10/$40/$80 OF		$10/$40/$80 OF		$10/$40/$80 OF	
Prescription Drug **Deductible**	$0		$0		$0		$0		$0		$0	
Purchased Plan Rates - Medical	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	19	$628.52	0	$765.28	9	$614.78	28	$448.97	28	$435.81	28	$455.47
Two Person (2P)	37	$1,412.29	1	$1,719.99	35	$1,475.45	73	$1,008.66	73	$979.10	73	$1,023.27
Family (FF)	77	$1,569.04	2	$1,910.94	29	$1,844.32	108	$1,120.60	108	$1,087.76	108	$1,136.85
Rx Rates/Equiv Breakout (as applicable)	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**
One Person (1P)	19	Included in Med	0	Included in Med	9	Included in Med	28	Included in Med	28	Included in Med	28	Included in Med
Two Person (2P)	37	Included in Med	1	Included in Med	35	Included in Med	73	Included in Med	73	Included in Med	73	Included in Med
Family (FF)	77	Included in Med	2	Included in Med	29	Included in Med	108	Included in Med	108	Included in Med	108	Included in Med
Total Annual Premium	133	$2,220,152	3	$66,502	78	$1,327,909	209	$2,486,738	209	$2,413,861	209	$2,522,780
Combined Annual Premium	$3,614,563		< TOTALS		< TOTALS							
Deductible & Coins Funding	**Deductible**	**Total**	**Deductible**	**Total**	**Deductible**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**
Exposure Basis - Individual	$0	$0	$0	$0	$500	$4,500	$250	$7,000	$500	$14,000	$500	$14,000
Exposure Basis - Family	$0	$0	$0	$0	$1,000	$64,000	$500	$90,500	$1,000	$181,000	$1,000	$181,000
Total Exposure		$0		$0		$68,500		$97,500		$195,000		$195,000
Combined Total Exposure	$68,500		< TOTALS		< TOTALS							
Estimated Utilization Rate	0%		0%		0%		0%		0%		0%	
Additional Ded, Coins., Rx Expense		$0		$0		$0		$0		$0		$0
Plan Extras Funding		Total		Total		Total		Total		Total		Total
Expected Claims Per Emp Per Month	$0.00		$0.00		$0.00		$0		$0		$0	
Estimated Plan Extras Expense		$0		$0		$0		$0		$0		$0
Administration	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**
Admin Fee	$0.00		$0.00		$0.00		$0.00		$0.00		$0.00	
Combined Total Administration		$0		$0		$0		$0		$0		$0
Resulting Plan Features	In Network		In Network		In Network		In Network		In Network		In Network	
Coinsurance	0%		10%		0%		0%		0%		0%	
Deductible Individual	$100		$50		$100		$250		$500		$500	
Deductible Family	$200		$100		$200		$500		$1,000		$1,000	
Post-Deductible Coinsurance - Individual	$0		$0		$500		$0		$0		$0	
Post-Deductible Coinsurance - Family	$0		$0		$1,000		$0		$0		$0	
Office Visit Copay	$10		n/a		$20		$20		$20		$20	
Rx Copay	$10/$20		$10/$20		$10/$20		$10/$40/$80 OF		$10/$40/$80 OF		$10/$40/$80 OF	
Prescription Drug Deductible	$0		$0		$0		$0		$0		$0	
Total Costs							**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**	**Annual**
Best Case Annual Cost	$3,614,563		<Totals		<Totals			$2,486,738		$2,413,861		$2,522,780
Estimated Annual Cost	$3,614,563		<Totals		<Totals			$2,486,738		$2,413,861		$2,522,780
Worst Case Annual Cost	$3,614,563		<Totals		<Totals			$2,486,738		$2,413,861		$2,522,780
Estimated Savings - $							$450	$1,127,826	$479	$1,200,703	$435	$1,091,783
Estimated Savings - %								31%		33%		30%
Final Illustrative Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	19	$628.52	0	$765.28	9	$614.78	28	$448.97	28	$435.81	28	$455.47
Two Person (2P)	37	$1,412.29	1	$1,719.99	35	$1,475.45	73	$1,008.66	73	$979.10	73	$1,023.27
Family (FF)	77	$1,569.04	2	$1,910.94	29	$1,844.32	108	$1,120.60	108	$1,087.76	108	$1,136.85

*If transitioning from another TPA, run-in claim administration will have a $5.00 pepm for first three months and $10.00 per claim thereafter

SET SEG

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

Medical Plan Comparison

West Branch-Rose City Area Schools

All Employees

	CURRENT PLAN Teachers, Administrators, and Support Staff with Choices II		CURRENT PLAN Teachers, Administrators, and Support Staff with Supercare		CURRENT PLAN Steelworkers		BCBSM SB HSA 1250-0%; $5/$25/$50 Rx		BCBSM SB HSA 1250-0%; $100/$200 Ded; $5/$25/$50 Rx		BCBSM SB HSA 3000-0%; $100/$200 Ded; $5/$25/$50 Rx	
Carrier	MESSA Choices II $10/$20		MESSA Supercare		BCBSM Community Blue 2 $10/$20 Rx		BCBSM		BCBSM		BCBSM	
Rate Period	7/1/2011 - 6/30/2012		7/1/2011 - 6/30/2012		7/1/2011 - 6/30/2012		9/1/2011 - 6/30/2012		9/1/2011 - 6/30/2012		9/1/2011 - 6/30/2012	
Purchased Plan Features	In Network		In Network		In Network		In Network		In Network		In Network	
Coinsurance	0%		10%		0%		0%		0%		0%	
Deductible Individual	$100		$50		$100		$1,250		$1,250		$3,000	
Deductible Family	$200		$100		$200		$2,500		$2,500		$6,000	
Post-Deductible Coinsurance - Individual	$0		$0		$500		$0		$0		$0	
Post-Deductible Coinsurance - Family	$0		$0		$1,000		$0		$0		$0	
Office Visit Copay	$10		n/a		$20		$0		$0		$0	
Rx Copay	$10/$20		$10/$20		$10/$20		$5/$25/$50		$5/$25/$50		$5/$25/$50	
Prescription Drug Deductible	$0		$0		$0		$0		$0		$0	
Purchased Plan Rates - Medical	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	19	$628.52	0	$765.28	9	$614.78	28	$386.73	28	$386.73	28	$280.28
Two Person (2P)	37	$1,412.29	1	$1,719.99	35	$1,475.45	73	$928.17	73	$928.17	73	$672.68
Family (FF)	77	$1,569.04	2	$1,910.94	29	$1,844.32	108	$1,160.21	108	$1,160.21	108	$840.84
Rx Rates/Equiv Breakout (as applicable)	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**
One Person (1P)	19	Included in Med	0	Included in Med	9	Included in Med	28	Included in Med	28	Included in Med	28	Included in Med
Two Person (2P)	37	Included in Med	1	Included in Med	35	Included in Med	73	Included in Med	73	Included in Med	73	Included in Med
Family (FF)	77	Included in Med	2	Included in Med	29	Included in Med	108	Included in Med	108	Included in Med	108	Included in Med
Total Annual Premium	133	$2,220,182	3	$66,502	73	$1,827,909	209	$2,446,650	209	$2,446,650	209	$1,773,170
Combined Annual Premium	$3,614,563		< TOTALS		< TOTALS							
Deductible & Coins Funding	**Deductible**	**Total**	**Deductible**	**Total**	**Deductible**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**
Exposure Basis - Individual	$0	$0	$0	$0	$500	$4,500	$1,250	$35,000	$1,150	$32,200	$2,900	$81,200
Exposure Basis - Family	$0	$0	$0	$0	$1,000	$64,000	$2,500	$452,500	$2,300	$416,300	$5,800	$1,049,800
Total Exposure		$0		$0		$68,500		$487,500		$448,500		$1,131,000
Combined Total Exposure	$68,500		< TOTALS		< TOTALS							
Estimated Utilization Rate	0%		0%		0%		100%		100%		100%	
Additional Ded, Coins., Rx Expense		$0		$0		$0		$487,500		$448,500		$1,131,000
Plan Extras Funding		**Total**		**Total**		**Total**		**Total**		**Total**		**Total**
Expected Claims Per Emp Per Month	$0.00		$0.00		$0.00		$0		$0		$0	
Estimated Plan Extras Expense		$0		$0		$0		$0		$0		$0
Administration	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**
Admin Fee	$0.00		$0.00		$0.00		$0.00		$0.00		$0.00	
Combined Total Administration		$0		$0		$0		$0		$0		$0
Resulting Plan Features	**In Network**		**In Network**		**In Network**		**In Network**		**In Network**		**In Network**	
Coinsurance	0%		10%		0%		0%		0%		0%	
Deductible Individual	$100		$50		$100		$0		$100		$100	
Deductible Family	$200		$100		$200		$0		$200		$200	
Post-Deductible Coinsurance - Individual	$0		$0		$500		$0		$0		$0	
Post-Deductible Coinsurance - Family	$0		$0		$1,000		$0		$0		$0	
Office Visit Copay	$10		n/a		$20		$0		$0		$0	
Rx Copay	$10/$20		$10/$20		$10/$20		$5/$25/$50		$5/$25/$50		$5/$25/$50	
Prescription Drug Deductible	$0		$0		$0		$0		$0		$0	
Total Costs							**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**	**Annual**
Best Case Annual Cost	$3,614,563		<Totals		<Totals			$2,934,150		$2,895,150		$2,904,170
Estimated Annual Cost	$3,614,563		<Totals		<Totals			$2,934,150		$2,895,150		$2,904,170
Worst Case Annual Cost	$3,614,563		<Totals		<Totals			$2,934,150		$2,895,150		$2,904,170
Estimated Savings - $							$271	$680,413	$287	$719,413	$283	$710,393
Estimated Savings - %								19%		20%		20%
Final Illustrative Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	19	$628.52	0	$765.28	9	$614.78	28	$463.79	28	$457.62	28	$459.05
Two Person (2P)	37	$1,412.29	1	$1,719.99	35	$1,475.45	73	$1,113.11	73	$1,098.31	73	$1,101.74
Family (FF)	77	$1,569.04	2	$1,910.94	29	$1,844.32	108	$1,391.38	108	$1,372.89	108	$1,377.16

***If transitioning from another TPA, run-in claim administration will have a $5.00 pepm for first three months and $10.00 per claim thereafter**

DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.

Medical Plan Comparison

West Branch-Rose City Area Schools

All Employees

	CURRENT PLAN Teachers, Administrators, and Support Staff with Choices II		CURRENT PLAN Teachers, Administrators, and Support Staff with Supercare		CURRENT PLAN Steelworkers		BCBSM/EHIM FB3 to First Dollar; $100/$200 ded; SF $10/$20 Rx		BCBSM/EHIM FB3 to School Plan II; $100/$200 ded; SF $10/$20 Rx		BCN Plan 10; $20 OV; $10/$20 Rx	
Carrier	MESSA Choices II $10/$20		MESSA Supercare		BCBSM Community Blue 2 $10/$20 Rx		BCBSM/EHIM		BCBSM/EHIM		Blue Care Network	
Rate Period	7/1/2011 - 6/30/2012		7/1/2011 - 6/30/2012		7/1/2011 - 6/30/2012		9/1/2011 - 6/30/2012		9/1/2011 - 6/30/2012		9/1/2011 - 6/30/2012	
Purchased Plan Features	In Network		In Network		In Network		In Network		In Network		In Network	
Coinsurance	0%		10%		0%		0%		0%		0%	
Deductible Individual	$100		$50		$100		$2,000		$2,000		$0	
Deductible Family	$200		$100		$200		$4,000		$4,000		$0	
Post-Deductible Coinsurance - Individual	$0		$0		$500		$0		$0		$1,000	
Post-Deductible Coinsurance - Family	$0		$0		$1,000		$0		$0		$2,000	
Office Visit Copay	$10		n/a		$20		$0		$0		$20	
Rx Copay	$10/$20		$10/$20		$10/$20		SF $10/$20		SF $10/$20		$10/$20	
Prescription Drug Deductible	$0		$0		$0		$0		$0		$0	
Purchased Plan Rates - Medical	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	19	$628.52	0	$765.28	9	$614.78	28	$292.72	28	$292.72	28	$453.64
Two Person (2P)	37	$1,412.29	1	$1,719.99	35	$1,475.45	73	$702.51	73	$702.51	73	$1,043.36
Family (FF)	77	$1,569.04	2	$1,910.94	29	$1,844.32	108	$878.15	108	$878.15	108	$1,247.50
Rx Rates/Equiv Breakout (as applicable)	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**	**Census**	**Rates/Equiv**
One Person (1P)	19	Included in Med	0	Included in Med	9	Included in Med	28	$87.65	28	$87.65	28	Included in Med
Two Person (2P)	37	Included in Med	1	Included in Med	35	Included in Med	73	$210.35	73	$210.35	73	Included in Med
Family (FF)	77	Included in Med	2	Included in Med	29	Included in Med	108	$297.99	108	$297.99	108	Included in Med
Total Annual Premium	133	$2,220,152	3	$66,502	79	$1,527,909	209	$2,451,747	209	$2,451,747	289	$2,683,166
Combined Annual Premium	$3,614,563		< TOTALS		< TOTALS							
Deductible & Coins Funding	**Deductible**	**Total**	**Deductible**	**Total**	**Deductible**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**	**Ded + Coins**	**Total**
Exposure Basis - Individual	$0	$0	$0	$0	$500	$4,500	$1,900	$53,200	$1,900	$53,200	$0	$0
Exposure Basis - Family	$0	$0	$0	$0	$1,000	$64,000	$3,800	$687,800	$3,800	$687,800	$0	$0
Total Exposure		$0		$0		$68,500		$741,000		$741,000		$0
Combined Total Exposure	$68,500		< TOTALS		< TOTALS							
Estimated Utilization Rate	0%		0%		0%		45%		45%		0%	
Additional Ded, Coins., Rx Expense		$0		$0		$0		$333,450		$333,450		$0
Plan Extras Funding		**Total**		**Total**		**Total**		**Total**		**Total**		**Total**
Expected Claims Per Emp Per Month	$0.00		$0.00		$0.00		$0		$25		$0	
Estimated Plan Extras Expense		$0		$0		$0		$0		$62,700		$0
Administration	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**	**PEPM**	**Total**
Admin Fee	$0.00		$0.00		$0.00		$15.50		$15.50		$0.00	
Combined Total Administration		$0		$0		$0		$33,874		$38,874		$0
Resulting Plan Features	**In Network**		**In Network**		**In Network**		**In Network**		**In Network**		**In Network**	
Coinsurance	0%		10%		0%		0%		0%		0%	
Deductible Individual	$100		$50		$100		$100		$100		$0	
Deductible Family	$200		$100		$200		$200		$200		$0	
Post-Deductible Coinsurance - Individual	$0		$0		$500		$0		$0		$1,000	
Post-Deductible Coinsurance - Family	$0		$0		$1,000		$0		$0		$2,000	
Office Visit Copay	$10		n/a		$20		$0		$0		$20	
Rx Copay	$10/$20		$10/$20		$10/$20		SF $10/$20		SF $10/$20		$10/$20	
Prescription Drug Deductible	$0		$0		$0		$0		$0		$0	
Total Costs							**PEPM**	**Annual**	**PEPM**	**Annual**	**PEPM**	**Annual**
Best Case Annual Cost	$3,614,563		<Totals		<Totals			$2,490,621		$2,490,621		$2,683,166
Estimated Annual Cost	$3,614,563		<Totals		<Totals			$2,824,071		$2,886,771		$2,683,166
Worst Case Annual Cost	$3,614,563		<Totals		<Totals			$3,231,621		$3,294,321		$2,683,166
Estimated Savings - $							$315	$790,492	$290	$727,792	$371	$931,397
Estimated Savings - %								22%		20%		26%
Final Illustrative Plan Rates	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**	**Census**	**Rates**
One Person (1P)	19	$628.52	0	$765.28	9	$614.78	28	$446.40	28	$456.31	28	$453.64
Two Person (2P)	37	$1,412.29	1	$1,719.99	35	$1,475.45	73	$1,071.34	73	$1,095.12	73	$1,043.36
Family (FF)	77	$1,569.04	2	$1,910.94	29	$1,844.32	108	$1,339.19	108	$1,368.92	108	$1,247.50

*If transitioning from another TPA, run-in claim administration will have a $5.00 pepm for first three months and $10.00 per claim thereafter

SET SEG

Medical Plan Disclaimers:

Please take note of the following disclaimers if you are interested in a Priority Health plan shown within this proposal.

PriorityHealth

Priority Health HSA plans post-deductible co-insurance only applies to a small number of services not covered at 100%. These services include TMJ, Orthognathic surgeries, other certain surgeries, and treatment for morbid obesity. Please refer to plan summary for details.

Final premium rates will vary slightly due to rounding.

Rates and benefit summaries may be pending and subject to approval by the Michigan Office of Financial and Insurance Regulation

All released quotes are based on enrollment provided by the group or agent (proposals) or extracted from the Priority Health system (renewals). Re-rating, including stop-loss premiums and attachment points, may be required if actual enrollment as of the effective date differs by 10% or more.

Priority Health's POS plans may not coexist with other carriers.

If two Priority Health plan designs coexist, there must be two or more differences in preferred base coinsurance, deductible, office visit copay, and/or Rx copay. Five or more must enroll in each offered plan design.

Other restrictions apply. Please contact your Priority Health Sales Representative for plan design approval and actual rates prior to finalizing the proposal or renewal. Priority Health is not liable for agent or employer group errors.

Small Group Specific:

1-10 Eligible Employees: 100% of eligible employees seeking coverage must participate. (One subscriber plans not available in East Region)

11-25 Eligible Employees: 75% of eligible employees seeking coverage must participate.

26-50 Eligible Employees: 50% of eligible employees seeking coverage must participate.

All groups with 2-50 Eligible Employees: Groups with a COBRA class are eligible if the participants make up less than 10% of the employees seeking coverage with PH. Retirees are

eligible if they make up less than 20% of employees seeking coverage with PH. Those eligible for Medicare must enroll in Medicare Parts A and B.

PriorityPPO: No more than 10% of enrolled employees can reside and work out of the service area

PriorityPPO:

- At least 50% of the enrolled employees must reside in the Priority Health service area.
- Groups may offer the PPO product for active out-of-area employees (retiree only class does not qualify) alongside another PH product for in-area employees. The in-area and out-of-area benefits should match as closely as possible.
- Subscribers in the PH service area will be enrolled in the PriorityPPO Network. Subscribers residing outside the service area must elect one of the selected National Networks as their primary network at the time of enrollment.
- If a member seeks services from a provider that participates with their primary network they will receive in network benefits.
- PriorityPPO is a regional network. Therefore, if a member seeks services outside the PriorityPPO service area, they may access selected network providers to receive in network benefits.

Guidelines for offering multiple plans: Groups with 11-25 Eligible Employees seeking coverage where PH is a total replacement may offer two benefit design options. Additionally, groups with 26-50 Eligible Employees seeking coverage where Priority Health is a total replacement may offer up to three benefit design options.

Any combination of plans EXCEPT HealthbyChoice Incentives may be offered.

- Minimum requirement of 5 enrolled contracts in each benefit level unless one of the plans is an HSA. There is a minimum requirement of 2 enrolled contracts in an HSA.
- Selected plans must either include or exclude Rx coverage.
- There must be at least two differences between the benefit designs in base coinsurance, deductible, office visit copayment and/or Rx copayment.
- If a "gatekeeper" versus a "non-gatekeeper" plan is offered, this will suffice for 2 of the plan differences.
- Only one benefit design may be offered to out-of-area employees. Depending on group size, a group may offer up to three benefit designs in-area and one benefit design out-of-area, for a total of up to four benefit designs.
- HRAs and HSAs will be allowed as a base product in any combination.
- At renewal, segments may be terminated if participation requirements are not met.

SET SEG

Medical Plan Disclaimers:

Please take note of the following disclaimers if you are interested in a Blue Cross Blue Shield of Michigan plan shown within this proposal.

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross Blue Shield Association.

BCBSM has the right to adjust rates if any of the assumptions or calculations used in the quoting process is incorrect.

BCBSB no longer markets Master Medical 65 as part of its supplemental coverage. If you choose to make any change in your medical benefit plan, and MM65 is part of your coverage, Master Medical will no longer be a part of your Medicare supplemental coverage.

Cost includes a 7% rate load for groups with less than 10 employees.

ERS specific:

BCBSM reserves the right to requote if enrollment or membership mix changes by greater than ten percent variance from the proposal assumptions. A final proposal may be completed once actual enrollment and benefit selections are known.

The ERS rates represent a formula III fully insured arrangement. The rates may also be used for illustrative purposes for a self-funded program.

ERS proposal may not be used to price the ERS 50-99 product.

SET SEG

Medical Plan Disclaimers:

Please take note of the following disclaimers if you are interested in a Blue Care Network of Michigan plan shown within this proposal.

BCN rates include the Family Continuation Rider for children ages 19-25. The additional cost per child in this age bracket is noted on the bottom of the Medical Rate Comparison page.

Any abbreviated descriptions do not replace the language in the certificate or rider brochure.

BCN of Michigan rates are guaranteed for the period stated in this proposal; however, BCN reserves the right to adjust rates if any of the assumptions or calculations used to calculate the rates are incorrect. Please remember that BCN is a prepaid health plan and payment is due on or before the date noted on your billing statement.

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of Blue Cross Blue Shield Association.

Client: West Branch Rose City

Simply Blue℠ PPO HSA – Plan 1250/0% Medical Coverage with Prescription Drug Coverage Benefits-at-a-Glance - w/CI, PCD, PDCM, XVA

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible, copay and/or coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

	In-network	Out-of-network *
Member's responsibility (deductibles, copays, coinsurance and dollar maximums) **Note:** if a PPO provider refers you to a non-network provider, all covered services obtained from that non-network provider will be subject to applicable out-of-network cost-sharing.		
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage.	$1,250 for a one-person contract or $2,500 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)	$2,500 for a one-person contract or $5,000 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)
Note: The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Please call your customer service center for an annual update.	
Fixed dollar copays	Based on prescription drug copay rider selected	Based on prescription drug copay rider selected
Coinsurance amounts **Note:** Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount
Annual coinsurance/copay dollar maximums **Note:** Your coinsurance/copay dollar maximum **combines** coinsurance/copay amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage.	$1,000 for a one-person contract or $2,000 for a family contract (2 or more members) each calendar year – applies to prescription drug copays	$2,000 for a one-person contract or $4,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

Preventive care services

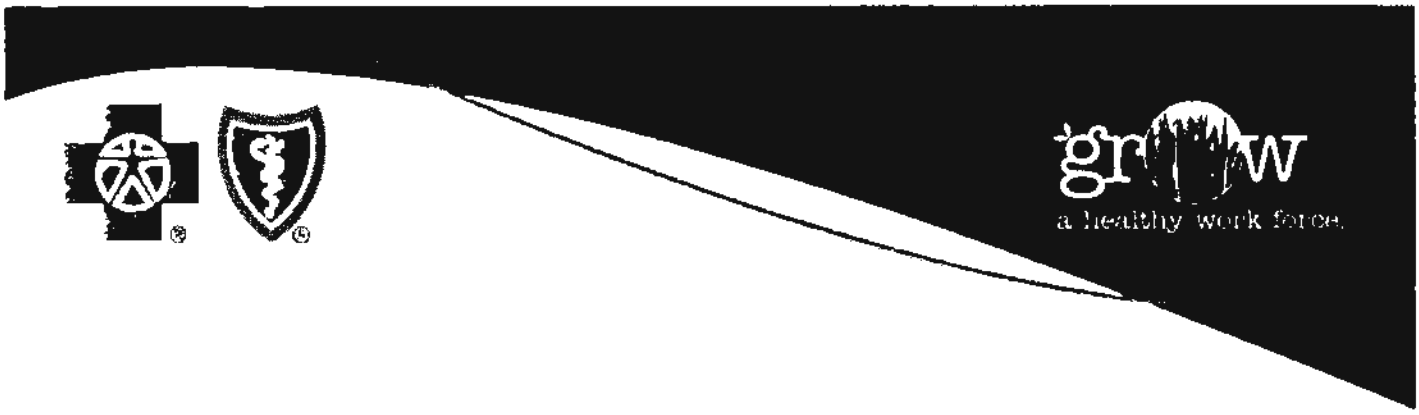
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

grow
a healthy work force.

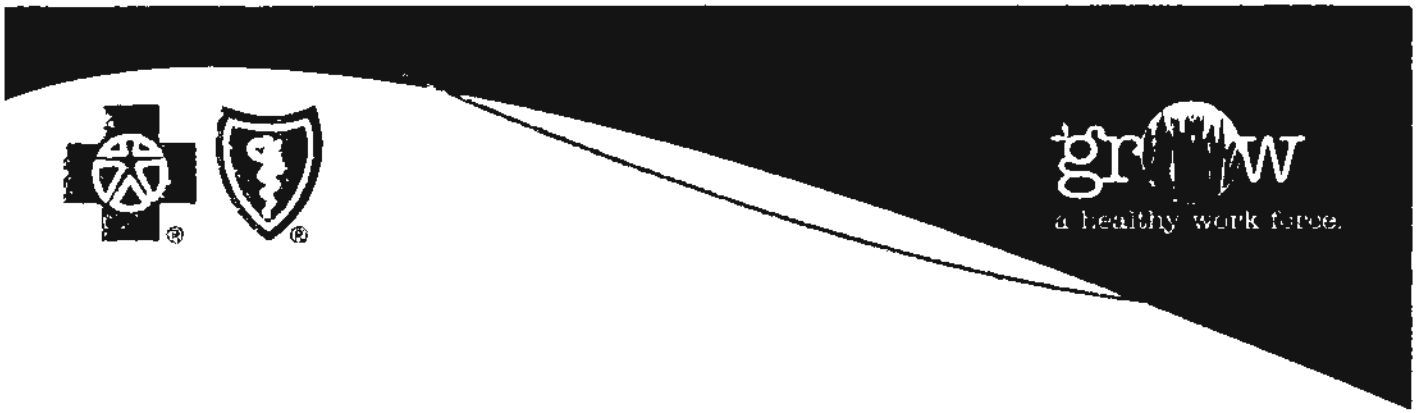
	In-network	Out-of-network *
Preventive care services, *continued*		
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible **Note:** Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies are subject to your deductible and coinsurance.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	
Physician office services		
Office visits	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits	100% after in-network deductible	80% after out-of-network deductible
Office consultations	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits	100% after in-network deductible	80% after out-of-network deductible
Emergency medical care		
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services – must be medically necessary	100% after in-network deductible	100% after in-network deductible
Diagnostic services		
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



	In-network	Out-of-network *
Maternity services provided by a physician		
Prenatal and postnatal care	100% after in-network deductible	80% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and services **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care – must be provided through a **participating** hospice program	100% after in-network deductible	100% after in-network deductible
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	100% after in-network deductible	100% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization	100% after in-network deductible	80% after out-of-network deductible
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible – in designated facilities **only**
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



	In-network	Out-of-network *

Mental health care and substance abuse treatment

Note: If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following coinsurance amounts. Mental health and substance abuse coinsurance amounts are included in the annual coinsurance maximums for all covered services. See "Annual coinsurance maximums" section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

Inpatient mental health care and inpatient substance abuse treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible, in participating facilities **only**
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Note: If your employer has **50 or fewer** employees (all employees, not just eligible employees), covered mental health and substance abuse services are subject to the following coinsurance amounts. Mental health and substance abuse coinsurance amounts are **not** limited to a coinsurance maximum.

Inpatient mental health care	100% after in-network deductible	80% after out-of-network deductible
	Limited to a maximum of 60 days per member per calendar year	
Inpatient substance abuse treatment	100% after in-network deductible	80% after out-of-network deductible
	Limited to a maximum of 60 days per member per calendar year	
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible, in participating facilities **only**
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
	Limited to a maximum of 120 visits per member per calendar year	
Outpatient substance abuse treatment – in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Other covered services

Outpatient Diabetes Management Program (ODMP) **Note:** Effective July 1, 2011, when you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay/coinsurance) for diabetes self-management training	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a **combined** maximum of 12 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** maximum of 30 visits per member per calendar year	
Durable medical equipment	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing	100% after in-network deductible	100% after in-network deductible

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

grow
a healthy work force.

Additional Riders Selected

Rider CI, contraceptive injections **Rider PCD,** prescription contraceptive devices **Rider PD-CM,** prescription contraceptive medications	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered). **Note:** These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.
Rider XVA, excludes voluntary abortions	Excludes benefits for voluntary abortions.

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Client: West Branch Rose City

Simply Blue℠ PPO HSA – Prescription Drug Coverage with $5 Generic / $25 Formulary (Preferred) Brand / $50 Nonformulary (Nonpreferred) Brand Triple-Tier Copay Open Formulary Benefits-at-a-Glance - w/PD-CM

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible, copay and/or coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com**. Log in under *I am a Member*. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual coinsurance/copay dollar maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug fixed dollar copays which are subject to your annual coinsurance/copay dollar maximums.

Note: Fixed dollar copays apply once the deductible has been met.

		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Tier 1 – Generic or prescribed over-the-counter drugs	1 to 30-day period	$5 copay	$5 copay	$5 copay	$5 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$10 copay	No coverage	No coverage
	84 to 90-day period	$10 copay	$10 copay	No coverage	No coverage
Tier 2 – Formulary (preferred) brand-name drugs	1 to 30-day period	$25 copay	$25 copay	$25 copay	$25 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$50 copay	No coverage	No coverage
	84 to 90-day period	$50 copay	$50 copay	No coverage	No coverage
Tier 3 – Nonformulary (nonpreferred) brand-name drugs	1 to 30-day period	$50 copay	$50 copay	$50 copay	$50 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$100 copay	No coverage	No coverage
	84 to 90-day period	$100 copay	$100 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

* BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

Covered services

	90-day retail network pharmacy	*** Network mail order provider**	**Network pharmacy** (not part of the 90-day retail network)	**Non-network pharmacy**
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network copay **
Prescribed over-the-counter drugs – when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network copay **
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network copay **
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay.	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug ***plus*** an additional 20% prescription drug out-of-network copay **

* BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

** The 20% prescription drug out-of-network copay will not be applied toward your Simply Blue HSA deductible or annual coinsurance/copay dollar maximum.

Features of your prescription drug plan

BCBSM Custom Formulary	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** – Tier 2 includes brand-name drugs from the Custom Formulary. Preferred brand name drugs are also safe and effective, but require a higher copay. • **Tier 3 (nonpreferred brand)** – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com**. Log in under *I am a Member* and click on *Prescription Drugs*.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Drug interchange and generic copay waiver	BCBSM's drug interchange and generic copay waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits. A list of these drugs is available at **bcbsm.com**.

Additional Riders Selected

Rider PD-CM, prescription contraceptive medications	Adds coverage for "RX only" FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).

PriorityHealth®

PRIORITY HEALTH
priorityhealth.com
PRIORITYPOS℠ (POINT OF SERVICE) PRODUCT
POS #3
West Branch Rose City Schools
September 1, 2011 - August 31, 2012

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 – 70/30% 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.	Certain services subject to a flat dollar Copayment, such as services received in or billed from your PCP's office, Specialist Provider's office or Urgent Care Center. However, emergency room services, ambulance services and advanced diagnostic imaging services could be subject to the Deductible in addition to a Copayment as noted below. Routine maternity care (the Deductible does apply to facility charges for delivery). Preventive health services.	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	$250	$500
Family Deductible per Contract Year	$500	$1,000

Maximums	Preferred Benefit – 100% Plan	Alternate Benefit – 70/30% 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	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	$2,500
Family Out-of-Pocket Maximum per Contract Year	Not applicable	$5,000
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 – 70/30% Plan	
Physician's Services	Deductible applies to all services except where indicated below		Deductible applies to all services	
Preventive Care Services	100%	Coverage of services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines. Deductible and copay do not apply.	70%	Coverage of services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines. Deductible applies
Primary Care Provider (PCP) Office Visit (face-to-face, telephonic or through secure electronic portal services provided by your PCP and other Participating Physician for the diagnosis and treatment of a covered illness or injury)	$20	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.	70%	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 coinsurance level. Deductible applies.
Specialist Office Visit (referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary)	$35	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.	70%	Coverage of reasonable and customary charges. Lab or X-ray services sent to another facility for analysis covered at coinsurance level. Deductible applies
Routine Pre and Post-natal Care	$20	Copayment per visit. Maximum of 4 copayments per pregnancy. (Deductible does not apply to routine maternity.)	70%	Coverage of reasonable and customary charges Deductible applies.
Allergy Care	100%	Coverage for injections and serum. Applicable office visit Copayment may apply for testing. Deductible does not apply to office vist or tests.	70%	Coverage of reasonable and customary charges Deductible applies.
Outpatient Services				
Diagnostic Laboratory and X-Ray	100%	Coverage. Deductible applies.	70%	Coverage of reasonable and customary charges Deductible applies.
Chemotherapy	100%	Coverage. Deductible applies.		
Radiation Therapy	100%	Coverage. Deductible applies.		
Hemodialysis	100%	Coverage. Deductible applies.		

Basic Benefits	Preferred Benefit – 100% Plan		Alternate Benefit – 70/30% Plan	
Rehabilitative Medicine Services				
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation)	$20	Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year. Deductible does not apply.	50%	Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. Deductible applies.
Speech Therapy	$20	Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year. Deductible does not apply.	50%	Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. Deductible applies.
Cardiac Rehabilitation and Pulmonary Rehabilitation	$20	Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year. Deductible does not apply.	50%	Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. Deductible applies.
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. 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 20% 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. Deductible applies. Prior approval is required for certain radiology examinations.	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.

[illegible]	[illegible]	[illegible]
Outpatient Hospital Professional Services	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.
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 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.
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. Prior approval is required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies to advanced diagnostic imaging. Note: Advanced diagnostic imaging tests at inpatient hospital or observation setting will not take a Copayment, but will be subject to applicable deductible and/or coinsurance.	70% Coverage of reasonable and customary charges Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies.
Emergency Medical Care (in or out of the service area)		
Hospital Emergency Room	$150 Copayment per visit (waived if admitted). Deductible applies.	$150 Copayment per visit (waived if admitted) Deductible applies.
Urgent Care Center	$75 Copayment per visit. Deductible does not apply.	70% Coverage of reasonable and customary charges. Deductible applies.
Physician's Office	$20 Copayment per visit. Deductible does not apply.	70% Coverage of reasonable and customary charges. Deductible applies.
Ambulance (land or air)	$150 Copayment. Deductible applies.	$150 Copayment. Deductible applies.

Basic Benefits	Preferred Benefit – 100% Plan	Alternate Benefit – 70/30% Plan
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.	Not Covered
	100% Coverage when in connection with other covered inpatient or outpatient surgery. Deductible applies.	Not Covered
Tubal Ligation		
Professional Fees	100% Coverage. Deductible applies.	Not Covered (including physicians' fees and any other related charges)
Outpatient	100% Coverage. Deductible applies.	Not Covered (including physicians' fees and any other related 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 related 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 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. Deductible applies. Non-emergency inpatient hospital admissions must be approved in advance by Priority Health	70% Coverage of reasonable and customary charges. Deductible applies. Failure to obtain prior approval will result in a 20% reduction of benefits.
Outpatient Mental Health & Substance Abuse Services (including medication management visits)	$20 Office visit copayment. Deductible does not apply.	70% Coverage of reasonable and customary charges per visit. Deductible applies.

Basic Benefits	Preferred Benefit – 100% Plan		Alternate Benefit – 70/30% Plan	
Other Services				
Dietician Services	$35	Copayment per visit. Up to six visits per Contract Year.		Not Covered
Durable Medical Equipment	100%	Coverage. Deductible applies.	50%	Coverage of reasonable and customary charges. Deductible applies.
Prosthetics & Orthotics	100%	Coverage. Deductible applies.	50%	Coverage of reasonable and customary charges. Deductible applies.
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	100%	Coverage. Deductible applies. Maximum 120 days per Contract Year.	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 (including Hospice Services, excluding Rehabilitative Medicine)	100%	Coverage. Deductible applies.	70%	Coverage of reasonable and customary charges. Deductible applies.
Temporomandibular Joint Syndrome (TMJS)	50%	Coverage. Deductible applies	50%	Coverage of reasonable and customary charges. Deductible applies.
Orthognathic Surgery	50%	Coverage. Deductible applies.	50%	Coverage of reasonable and customary charges. Deductible applies.

Eligibility Information	
Dependent Children	Covered until dependent reaches age 26.
Early Retiree Coverage	May be Available
65+ Retiree Coverage	May be Available

Additional Benefits or Copayments

Additional Benefits	
Pharmacy Services	
Prescription Drugs **Note:** Prescription drug coverage is based on the usage of a medication formulary. **Drugs Requiring Administration by a Health Professional:** Injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or outpatient facility. Step therapy may be required before drug will be Covered **Includes approved preventive medication**	**Tier 1-Generic Drugs** $10 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 3-Non-Preferred Brand-Name Drugs** $80 Copay per prescription or refill for a Non-Preferred Brand-Name Drug Subject to Prior Authorization and/or Step Therapy **Tier 4-Preferred Specialty Drugs** 20% Copayment for a preferred Specialty Drug. The maximum Copayment per prescription or refill for a preferred Specialty Drug is $100. Subject to Prior Authorization and/or Step Therapy. **Tier 5-Non-Preferred Specialty Drugs** 20% Copayment for a non-preferred Specialty Drug. The maximum Copayment per prescription or refill for a non-preferred Specialty Drug is $200. Subject to Prior Authorization and/or Step Therapy. **Infertility Treatment** 50% Copay for drugs used for treating infertility. (Limitations apply) **Contraceptive** 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. **SPECIALTY DRUGS COPAYMENT MAXIMUM PER CONTRACT YEAR** The maximum Preferred and Non-Preferred Specialty Drugs Copayments under the prescription drugs benefits is $2,400 per Member per Contract Year
Prescription Mail Order Filled for up to 90 days	**Tier 1- Generic Drugs** $20 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $80 Copay per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** $160 Copay per prescription or refill for a Non-Preferred Brand-Name Drug **Tier 4- Preferred Specialty Drugs** 20% Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. **Tier 5- Non-Preferred Specialty Drugs** 20% Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. **Contraceptive** Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply)

PriorityHealth®

PRIORITY HEALTH
priorityhealth.com
PRIORITYPOS℠ (POINT OF SERVICE) PRODUCT
POS #3
West Branch Rose City Schools
September 1, 2011 - August 31, 2012

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 – 70/30% 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.	Certain services subject to a flat dollar Copayment, such as services received in or billed from your PCP's office, Specialist Provider's office or Urgent Care Center. However, emergency room services, ambulance services and advanced diagnostic imaging services could be subject to the Deductible in addition to a Copayment as noted below. Routine maternity care (the Deductible does apply to facility charges for delivery). Preventive health services.	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	$500	$1,000
Family Deductible per Contract Year	$1,000	$2,000

Maximums	Preferred Benefit – 100% Plan	Alternate Benefit – 70/30% 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	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	$2,500
Family Out-of-Pocket Maximum per Contract Year	Not applicable	$5,000
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 – 70/30% Plan	
Physician's Services	Deductible applies to all services except where indicated below		Deductible applies to all services	
Preventive Care Services	100%	Coverage of services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines. Deductible and copay do not apply.	70%	Coverage of services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines. Deductible applies
Primary Care Provider (PCP) Office Visit (face-to-face, telephonic or through secure electronic portal services provided by your PCP and other Participating Physician for the diagnosis and treatment of a covered illness or injury)	$20	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.	70%	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 coinsurance level. Deductible applies.
Specialist Office Visit (referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary)	$35	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.	70%	Coverage of reasonable and customary charges. Lab or X-ray services sent to another facility for analysis covered at coinsurance level. Deductible applies
Routine Pre and Post-natal Care	$20	Copayment per visit. Maximum of 4 copayments per pregnancy. (Deductible does not apply to routine maternity.)	70%	Coverage of reasonable and customary charges Deductible applies.
Allergy Care	100%	Coverage for injections and serum. Applicable office visit Copayment may apply for testing. Deductible does not apply to office vist or tests.	70%	Coverage of reasonable and customary charges Deductible applies.
Outpatient Services				
Diagnostic Laboratory and X-Ray	100%	Coverage. Deductible applies.	70%	Coverage of reasonable and customary charges Deductible applies.
Chemotherapy	100%	Coverage. Deductible applies.		
Radiation Therapy	100%	Coverage. Deductible applies.		
Hemodialysis	100%	Coverage. Deductible applies.		

Basic Benefits	Preferred Benefit – 100% Plan		Alternate Benefit – 70/30% Plan	
Rehabilitative Medicine Services				
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation)	$20	Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year. Deductible does not apply	50%	Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. Deductible applies.
Speech Therapy	$20	Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year. Deductible does not apply.	50%	Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. Deductible applies.
Cardiac Rehabilitation and Pulmonary Rehabilitation	$20	Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year. Deductible does not apply.	50%	Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. Deductible applies.
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. 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 20% 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. Deductible applies. Prior approval is required for certain radiology examinations.	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.

PriorityHealth®

Basic Benefits	Preferred Benefit – 100% Plan	Alternate Benefit – 70/30% Plan
Outpatient Hospital Professional Services	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.
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 for each certain surgery or treannent, 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.
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. Prior approval is required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies to advanced diagnostic imaging. Note: Advanced diagnostic imaging tests at inpatient hospital or observation setting will not take a Copayment, but will be subject to applicable deductible and/or coinsurance.	70% Coverage of reasonable and customary charges Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies.
Emergency Medical Care (in or out of the service area)		
Hospital Emergency Room	$150 Copayment per visit (waived if admitted). Deductible applies.	$150 Copayment per visit (waived if admitted) Deductible applies.
Urgent Care Center	$75 Copayment per visit. Deductible does not apply.	70% Coverage of reasonable and customary charges. Deductible applies.
Physician's Office	$20 Copayment per visit. Deductible does not apply.	70% Coverage of reasonable and customary charges. Deductible applies.
Ambulance (land or air)	$150 Copayment. Deductible applies.	$150 Copayment. Deductible applies.

Basic Benefits	Preferred Benefit – 100% Plan		Alternate Benefit – 70/30% Plan	
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.		Not Covered
	100%	Coverage when in connection with other covered inpatient or outpatient surgery. Deductible applies.		Not Covered
Tubal Ligation				
Professional Fees	100%	Coverage. Deductible applies.		Not Covered (including physicians' fees and any other related charges)
Outpatient	100%	Coverage. Deductible applies.		Not Covered (including physicians' fees and any other related 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 related 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 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. Deductible applies. Non-emergency inpatient hospital admissions must be approved in advance by Priority Health	70%	Coverage of reasonable and customary charges. Deductible applies. Failure to obtain prior approval will result in a 20% reduction of benefits.
Outpatient Mental Health & Substance Abuse Services (including medication management visits)	$20	Office visit copayment. Deductible does not apply.	70%	Coverage of reasonable and customary charges per visit. Deductible applies.

Basic Benefits	Preferred Benefit – 100% Plan		Alternate Benefit – 70/30% Plan	
Other Services				
Dietician Services	$35	Copayment per visit. Up to six visits per Contract Year.		Not Covered
Durable Medical Equipment	100%	Coverage. Deductible applies.	50%	Coverage of reasonable and customary charges. Deductible applies.
Prosthetics & Orthotics	100%	Coverage. Deductible applies.	50%	Coverage of reasonable and customary charges. Deductible applies.
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	100%	Coverage. Deductible applies. Maximum 120 days per Contract Year.	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 (including Hospice Services, excluding Rehabilitative Medicine)	100%	Coverage. Deductible applies.	70%	Coverage of reasonable and customary charges. Deductible applies.
Temporomandibular Joint Syndrome (TMJS)	50%	Coverage. Deductible applies.	50%	Coverage of reasonable and customary charges. Deductible applies.
Orthognathic Surgery	50%	Coverage. Deductible applies	50%	Coverage of reasonable and customary charges. Deductible applies.

Eligibility Information	
Dependent Children	Covered until dependent reaches age 26.
Early Retiree Coverage	May be Available
65+ Retiree Coverage	May be Available

Additional Benefits or Copayments

Additional Benefits	
Pharmacy Services	
Prescription Drugs **Note:** Prescription drug coverage is based on the usage of a medication formulary. **Includes approved preventive medication**	**Tier 1-Generic Drugs** $10 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 3-Non-Preferred Brand-Name Drugs** $80 Copay per prescription or refill for a Non-Preferred Brand-Name Drug. Subject to Prior Authorization and/or Step Therapy. **Tier 4-Preferred Specialty Drugs** $80 Copayment for a preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy **Tier 5-Non-Preferred Specialty Drugs** $80 Copayment for a non-preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy. **Infertility Treatment** 50% Copay for drugs used for treating infertility. (Limitations apply) **Contraceptive** 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 **SPECIALTY DRUGS COPAYMENT MAXIMUM PER CONTRACT YEAR** No Copay Maximum
Prescription Mail Order Filled for up to 90 days	**Tier 1- Generic Drugs** $20 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $80 Copay per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** $160 Copay per prescription or refill for a Non-Preferred Brand-Name Drug **Tier 4- Preferred Specialty Drugs** $80 Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. **Tier 5- Non-Preferred Specialty Drugs** $80 Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. **Contraceptive** Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply)

PriorityHealth®

Benefit Summary

PriorityPPO℠ Premier

PPO PREMIER #3

West Branch Rose City Schools

September 1, 2011 - August 31, 2012

100% Network Benefit — 70% Non-Network Benefit

The PPO plan offers you a choice of two benefit levels. The Network Benefits level applies when you use a Network provider. Your out-of-pocket costs are lower when you use this option. The Non-Network level applies when you seek medical services from a Non-Network provider.

The following information is provided as a summary of benefits available under your PPO plan. This summary is not intended as a substitute for your Policy and Schedule of Benefits. It is not a binding contract. Limitations and exclusions apply to benefits listed below. A complete listing of covered services, limitations and exclusions is contained in the Policy, Schedule of Benefits and any applicable Addenda issued to you. You may request a copy of the Policy from Priority Health's Customer Service Department at 616 464-8830 or 888 389-6645 or on our web site priorityhealth.com. Contact Priority Health's Customer Service Department if you have questions about your benefits or Coverage.

Prior Approval

Prior approval is required before you may obtain certain services. If you seek services that require prior approval, without receiving prior approval from us, you will receive a reduction in benefit coverage for those services. You will also be responsible for those services that are beyond those approved, beyond the benefit maximums or excluded from Coverage.

You or your physician must call 800 269-1260 to obtain prior approval for services. Emergency admissions must be notified to us as soon as reasonably possible after admission.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS

A. Deductibles:

The Deductible is the amount of Covered Services you must incur during the Contract Year before benefits will be paid. The Network Benefits Deductible is applicable to all Covered Services except:

- Certain services subject to a flat dollar Copayment, such as services received in or billed from your PCP's office, Specialist Provider's office or Urgent Care Center. However, emergency room services, ambulance services and advanced diagnostic imaging services could be subject to the Deductible in addition to a Copayment as noted below.
- Routine maternity care (the Deductible does apply to facility charges for delivery).

- Preventive health services, services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness or disability.

The Non-Network Benefit Deductible is applicable to all Covered Services, except for flat dollar copayments, received under the Non-Network Benefit level or received from Non-Network providers.

The amounts calculated towards the Non-Network benefits Deductible also apply to the Network Benefits Deductibles. The Network Benefits Deductibles do not apply to the Non-Network Benefits Deductibles. Deductible amounts you pay, whether under the Network Benefits or Non-Network Benefits, are excluded from any Network or Non-Network Out-of-Pocket Maximums.

The Deductible renews each Contract Year. Any Deductible amount paid under the Network Benefits during the ninety (90) days preceding the start of a new Contract Year will carry over into the new Contract Year. Deductible amounts paid under the Non-Network Benefits do not carry over into a new Contract Year. The Family Deductible is not to exceed the Individual Deductible per person.

Deductibles	Network Benefits	Non-Network Benefits
Individual Contract	$500	$1,000
Family Contract	$1,000	$2,000

B. Out-of-Pocket Maximums:

The Out-of-Pocket Maximum applies to certain services. The Out-of-Pocket maximum limits the total amount of covered expenses that you and/or your covered dependents will pay during a Contract Year, except as described below.

Out-of-Pocket Maximums	Network Benefits	Non-Network Benefits
Individual	Not applicable	$2,500
Family	Not applicable	$5,000

The amounts calculated towards the Non-Network Benefits Deductible also apply to the Network Benefits Deductibles. The Network Benefits Deductibles do not apply to the Non-Network Benefits Deductibles. Deductible amounts you pay, whether under the Network Benefits or Non-Network Benefits, are excluded from any Network or Non-Network Out-of-Pocket Maximums.

Amounts paid for any of the following will not apply toward the Out-of-Pocket Maximum:

- Any flat dollar Coinsurance, such as Coinsurance for office visits, ambulance and emergency services.
- Penalties
- Deductibles
- Durable medical equipment
- Prosthetic and orthotic/support devices
- Orthognathic surgery
- Temporomandibular joint dysfunction or syndrome
- Port wine stains
- Certain surgeries

After meeting the Out-of-Pocket Maximums, the Coinsurance for these services still apply.

Note:

- Coinsurance made for any Covered Services obtained under a supplemental benefit Addendum may not be applied toward the above Out-of-Pocket Maximum. If your plan has a Deductible, the Deductible amounts you pay will not apply toward the Out-of-Pocket Maximum.

- If the Network or Non-Network Benefits Individual Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Reasonable and Customary Charges for Covered Services that apply toward out-of-pocket maximums as incurred by that person for the rest of the Contract Year. If the Network or Non-Network Benefits Family Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Reasonable and Customary Charges for Covered Services incurred by you and all your covered dependents for the rest of the Contract Year.

- If the non-notification penalty applies, the amount Priority Health pays will be reduced even if the Out-of-Pocket Maximum has been reached.

C. Maximum Individual Annual Benefit:

$5,000,000 is the combined benefit per insured for all Network and Non-Network covered services. (Any reduction in benefits/penalty will apply to the maximum individual benefit.)

Covered Benefits

Benefits	Network Benefits	Non-Network Benefits
Preventive Health Services	100% Coverage of services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines. Deductible and copay do not apply.	70% Coverage of Reasonable and Customary Charges Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums

Benefits	Network Benefits		Non-Network Benefits	
PHYSICIAN SERVICES				
Office and Home Visits (evaluation and management services only)	$20 $35	Copayment. Deductible does not apply. Copayment per Specialty Care visit. Deductible does not apply.	70%	Coverage of Reasonable and Customary Charges for face-to-face visits only Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Inpatient Hospital Visits	100%	Coverage Deductible applies	70%	Coverage of Reasonable and Customary Charges Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Surgery	100%	Coverage Deductible applies	70%	Coverage of Reasonable and Customary Charges Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Ambulatory Surgery Center Services	100% Appropriate Copayment (Primary Care or Specialty Care) per visit for physician office services	Coverage for physician surgical charges. Deductible applies.	70%	Coverage of Reasonable and Customary Charges Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Obstetrical Services (Routine prenatal delivery and postnatal evaluation and management services only)	$20	Copayment per visit up to a maximum of 4 copayments per pregnancy for routine prenatal and postnatal services only. Deductible does not apply.	70%	Coverage of Reasonable and Customary Charges Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums

Benefits	Network Benefits		Non-Network Benefits	
Physician Services (continued)				
Vasectomy	100%	Coverage for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery. Deductible applies	70%	Coverage for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
	100%	Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery. Deductible applies.	70%	Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Tubal Ligation	100%	Coverage for Physician services Coverage for outpatient facility charges Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums	70%	Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Consultations, pre-operative and post-operative visits (Evaluation and management services only)	$20	Copayment may apply	70%	Coverage of Reasonable and Customary Charges Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Allergy Testing	100%	Coverage Deductible applies.	70%	Coverage of Reasonable and Customary Charges Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums

Benefits	Network Benefits	Non-Network Benefits
Physician Services (continued)		
Allergy Injections	100% Coverage Deductible applies.	70% Coverage of Reasonable and Customary Charges Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Family Planning	100% Coverage Deductible applies.	70% Coverage of Reasonable and Customary Charges Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Infertility Services (Covered for diagnosis and treatment of underlying cause only)	100% Coverage Deductible applies.	70% Coverage of Reasonable and Customary Charges Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Infertility Services (Covered for diagnosis and treatment of underlying cause only)	50% Coverage (including physicians' fees and any other related charges) Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies	50% Coverage (including physicians' fees and any other related charges) Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies
Temporomandibular Joint Dysfunction or Syndrome	50% Coverage (including physicians' fees and any other related charges) Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies	50% Coverage (including physicians' fees and any other related charges) Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies
Orthognathic Surgery	50% Coverage (including physicians' fees and any other related charges) Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies	50% Coverage (including physicians' fees and any other related charges) Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies

Benefits	Network Benefits	Non-Network Benefits
Physician Services (continued)		
Certain Surgeries and Treatments (Physician fees only) Reconstructive surgery: blepharoplasty of upper lids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty* and surgical treatment of male gynecomastia Skin Disorder Treatments: Scar revision, 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. Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies.	Physician fees are Covered at 50% of the first $2,000 for each certain surgery or treatment, 100% thereafter. Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies.
Treatment of Morbid Obesity Weight loss programs Bariatric surgery – limit one per lifetime	Physician fees are Covered at 50% of the first $2,000 for each certain surgery or treatment, 100% thereafter. Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies.	Physician fees are Covered at 50% of the first $2,000 for each certain surgery or treatment, 100% thereafter. Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies.

Benefits	Network Benefits		Non-Network Benefits	
HOSPITAL SERVICES (Including radiology examinations and laboratory services)				
Inpatient Hospital Services (Including observation care, transplants and maternity stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section)	100%	Coverage Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Notification required for admissions following emergency room care Deductible applies	70%	Coverage of Reasonable and Customary Charges Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Notification required for admissions following emergency room care Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Outpatient Hospital Services (Including ambulatory surgery center facility charges)	100%	Coverage Some services may require prior approval Deductible applies	70%	Coverage of Reasonable and Customary Charges Some services may require prior approval Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
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. Prior approval is required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies to advanced diagnostic imaging. Note: Advanced diagnostic imaging tests at inpatient hospital or observation setting will not take a Copayment, but will be subject to applicable deductible and/or coinsurance.	70%	Coverage of Reasonable and Customary Charges Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums

Benefits	Network Benefits		Non-Network Benefits	
Medical Emergency and Urgent Care Services				
Emergency Room Services	$150	Copayment per visit. (Copayment waived only if you become confined as an inpatient in a Hospital.) Deductible applies.	$150	Copayment per visit. (Copayment waived only if you become confined as an inpatient in a Hospital.) Deductible applies.
Urgent Care Facility Services	$75	Copayment per visit (Copayment applies to all Urgent Care visits) Deductible does not apply.	70%	Coverage of Reasonable and Customary Charges Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums
Ambulance Services	$150	Copayment. Deductible applies.	$150	Copayment. Deductible applies.
BEHAVIORAL HEALTH Prior approval by our Behavioral Health Department is required as noted. Call 616 464-8500 or 800 673-8043				
Mental Health and Substance Abuse Inpatient (including partial hospitalization)	100%	Coverage Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies	70%	Coverage of Reasonable and Customary Charges Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies
Mental Health and Substance Abuse Outpatient	$20	Copayment per visit, including med management. Deductible does not apply.	70%	Coverage of Reasonable and Customary Charges per visit Deductible applies

Benefits	Network Benefits		Non-Network Benefits	
OTHER SERVICES				
Dietician Services	$35	Copayment per visit. Up to six visits per Contract Year.		Not Covered (including Physicians' fees and any other related charges)
Durable Medical Equipment (Rent, purchase or repair)	100%	Coverage Prior approval required for devices over $1,000 Deductible applies	50%	Coverage of Reasonable and Customary Charges Prior approval required for devices over $1,000
Prosthetic and Orthotics/Support Devices	100%	Coverage Prior approval required for devices over $1,000 Deductible applies	50%	Coverage of Reasonable and Customary Charges Prior approval required for devices over $1,000
Facility Services (Non-hospital) Skilled Nursing Subacute Inpatient Rehabilitation Hospice	100%	Coverage up to the benefit maximum of 120 days per Contract Year* Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies	70%	Coverage of Reasonable and Customary Charges up to the benefit maximum of 45 days per Contract Year* Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies Amounts paid after deductible do apply toward out-of-pocket
Home Health Care (including Hospice Services, excluding Rehabilitative Medicine) Note: Rehabilitative services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described below.	100%	Coverage of Reasonable and Customary Charges Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums	70%	Coverage of Reasonable and Customary Charges Prior approval required. Failure to obtain prior approval will result in a $250 reduction in benefits. Deductible applies Amounts paid after deductible do apply toward out-of-pocket maximums

Benefits	Network Benefits		Non-Network Benefits	
REHABILITATIVE MEDICINE SERVICES				
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation)	$20	Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year. Deductible does not apply.	50%	Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. Deductible applies.
Speech Therapy	$20	Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year. Deductible does not apply.	50%	Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. Deductible applies.
Cardiac Rehabilitation and Pulmonary Rehabilitation	$20	Copayment per visit up to a combined benefit maximum of 40 visits per Contract Year. Deductible does not apply.	50%	Coverage of reasonable and customary charges up to the combined benefit maximum of 40 visits per Contract Year. Deductible applies.

Eligibility Information	
Dependent Children	Covered until dependent reaches age 26.
Early Retiree Coverage	May be Available
65+ Retiree Coverage	May be Available

MAXIMUM LIMITATIONS

A. Benefit Maximums:

Benefit Maximums: Benefit maximums up to a certain number of days/visits/dollar amounts per Contract Year are reached by combining either Network or Non-Network Benefits up to the limit for one or the other, but not both. (Example: If Network Benefits is for 60 visits and Non-Network Benefits is for 60 visits, the maximum benefit is 60 visits, not 120.) The Family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person. Benefit maximums apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum. The Family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person.

Additional Benefits or Copayments

Additional Benefits	
Preferred Network Pharmacy Services	
Prescription Drugs **Note:** Prescription drug coverage is based on the usage of a medication formulary. **Includes approved preventive medication**	**Tier 1-Generic Drugs** $10 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 3-Non-Preferred Brand-Name Drugs** $80 Copay per prescription or refill for a Non-Preferred Brand-Name Drug. Subject to Prior Authorization and/or Step Therapy. **Tier 4-Preferred Specialty Drugs** $80 Copayment for a preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy. **Tier 5-Non-Preferred Specialty Drugs** $80 Copayment for a non-preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy. **Infertility Treatment** 50% Copay for drugs used for treating infertility. (Limitations apply) **Contraceptive** 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. **SPECIALTY DRUGS COPAYMENT MAXIMUM PER CONTRACT YEAR** No Copay Maximum
Prescription Mail Order Filled for up to 90 days	**Tier 1- Generic Drugs** $20 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $80 Copay per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** $160 Copay per prescription or refill for a Non-Preferred Brand-Name Drug **Tier 4- Preferred Specialty Drugs** $80 Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. **Tier 5- Non-Preferred Specialty Drugs** $80 Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. **Contraceptive** Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply)