

PRIORITY HEALTH
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SUMMARY OF BENEFITS HMO 70/30% HOSPITAL PLAN
STATE MANDATED INDIVIDUAL COVERAGE ENHANCED PLAN
Health Care Reform – Non-Grandfathered Members
05/01/2012 – 04/30/2013

The following information is provided as a summary of benefits available under your Priority Health plan. This summary is not 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 via e-mail at customer.service@priority-health.com. Contact Priority Health's Customer Service Department if you have questions about your benefits or coverage.

Copayment = Member pays

% Coverage = Priority Health pays

Deductibles

Individual Deductible per Contract Year	\$3,000
Family Deductible per Contract Year	\$6,000

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.

Any deductible amounts satisfied during the ninety (90) days preceding the start of the new contract year will carry over into the new contract year.

Note: Services applied to individual deductibles will be combined to satisfy the family deductible. The family deductible is not to exceed the individual deductible per person.

Maximums

Note: Out-of-Pocket maximum is the amount of covered expenses that you or your covered dependents will pay.

If the individual out-of-pocket maximum is reached during a Contract Year, Priority Health will pay 100% of covered hospital expenses incurred by that person for the rest of the Contract Year. If the family maximum is reached during a Contract Year, Priority Health will pay 100% of covered hospital expenses for you and all of your covered dependents for the rest of that Contract Year.

Only Copayments for inpatient and outpatient facility services apply to out-of-pocket maximum.

Individual Out-of-Pocket Maximum per Contract Year	\$2,500
Family Out-of-Pocket Maximum per Contract Year (but not to exceed the Individual Out-of-Pocket m	\$5,000

Preventive Health Care Services

Covered in full within Priority Health Preventive Health Care Guidelines. Office visit copayment may apply. Deductible does not apply.

Basic Benefits

Physician's Services

Primary Care Provider (PCP) Office Visit (services provided by a PCP during an office visit for health maintenance and preventive care, such as a routine physical, or for the diagnosis and treatment of a covered illness or injury)	\$40 Copayment per visit. Lab or X-ray services sent to another facility for analysis covered at 70%. Deductible does not apply.
Specialist Office Visit (referral care provided by a physician other than your PCP with appropriate referral from your PCP and prior approval from Priority Health if necessary)	\$55 Copayment per visit. Lab or X-ray services sent to another facility for analysis covered at 70%. Deductible does not apply.

Routine Pre and Post-natal Care	\$40 Copayment per visit. Maximum Copayment of \$160 per pregnancy. Deductible does not apply.
Allergy Care	100% Coverage for testing, injections and serum.
Advanced Diagnostic Imaging Services (such as CT, CTA, MRI, MRA, Nuclear Cardiology Studies, PET Scan)	\$150.00 Copayment (Copayment waived if performed while confined in a Hospital as an inpatient) Maximum 10 Copayments per individual per Contract year for advanced imaging services. Prior approval is required for certain radiology examinations
Standard Radiology Examinations and Laboratory Procedures <i>(In a non-hospital facility or physician's office)</i>	Covered in full if Preventive Health Care Service under Priority Health's preventive health care guidelines Appropriate office visit Copayment (PCP or other Participating Physician) may apply for physician office services 70% Coverage if billed by a Participating Provider other than a physician's office.
Speech Therapy Cardiac Rehabilitation and Pulmonary Rehabilitation Physical and Occupational Therapy	\$40 Copayment per visit for 30 visits per Contract Year (combined benefit for all therapies listed). Deductible does not apply.
Hospital Services	
Inpatient Services (semi-private room and intensive care, surgery and all related surgical services, ancillary services while inpatient, professional services) Note: Non-emergency inpatient hospital admissions, other than for normal labor and delivery, must be approved in advance by Priority Health.	70% Coverage
Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services, professional services)	70% Coverage
Certain Surgeries and Treatments (Physician fees only) <ul style="list-style-type: none"> • <i>Bariatric surgery</i> • Reconstructive surgery <ul style="list-style-type: none"> ○ Blepharoplasty of upper lids ○ Breast reduction ○ <i>Panniculectomy</i> ○ <i>Rhinoplasty</i> ○ <i>Septorhinoplasty</i> ○ Surgical treatment of male gynecomastia • Skin disorder treatments <ul style="list-style-type: none"> ○ Scar revisions ○ Keloid scar treatment ○ Treatment of hyperhidrosis ○ Excision of lipomas ○ Excision of seborrheic keratoses ○ Excision of skin tags ○ Treatment of vitiligo ○ Port wine stain and hemangioma treatment • Varicose veins treatments 	Physician fees are Covered at 50% of the first \$2,500 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. Deductible applies. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty treatment procedures.
Emergency Medical Care (in or out of the service area)	
Hospital Emergency Room	\$150 Copayment per visit (waived if admitted)
Urgent Care Center	\$75 Copayment per visit Deductible does not apply
Ambulance	\$150 Copayment (land or air)

Family Planning/Infertility Services	
Vasectomy	100% Coverage when performed in a provider's office or when performed in physician's office or when in connection with other covered inpatient or outpatient surgery. 70% Coverage for outpatient and inpatient facility charges only when in connection with other covered inpatient or outpatient surgery.
Tubal Ligation	
Professional Fees	100% Coverage.
Outpatient facility	70% Coverage
Inpatient facility	70% Coverage only when performed in connection with delivery or other covered inpatient surgery.
Infertility counseling and treatment of underlying cause of infertility	50% Coverage for diagnostic, counseling and planning services for treatment of the underlying cause of infertility Prescription drugs not covered.
Mental Health/Substance Abuse Services	
Note: All Mental Health and Substance Abuse services must be approved in advance by our Behavioral Health Department 616 464-8500 or 800 673-8043. Treatment may be covered as deemed clinically necessary by our Behavioral Health Department.	
Inpatient Mental Health Services	70% Coverage. Maximum 20 days per Contract Year.
Outpatient Mental Health Services	\$40 Copayment. Maximum 20 visits per Contract Year. (\$20.00 Copayment per group therapy visit – two group therapy visits count as one outpatient visit) Deductible does not apply.
Substance Abuse Services	70% Coverage up to the minimum annual benefit as determined by the State of Michigan per Contract Year.
Miscellaneous	
Durable Medical Equipment	50% Coverage
Prosthetics & Orthotics	50% Coverage
Skilled Nursing, Subacute, Long-Term Acute, Inpatient Rehabilitation and Hospice Facility	70% Coverage. Maximum 45 days per Contract Year (combined benefit for all services).
Home Health Care	Covered in full. For rehabilitative therapy provided in the home, refer to Rehabilitative Medicine services for Copayment information.
Temporomandibular Joint Syndrome (TMJS)	50% Coverage
Orthognathic Surgery	50% Coverage

Additional Benefits	
Pharmacy	
Prescription Drugs	No coverage
Prescription Mail Order	No coverage

Eligibility Information	
Dependent Children	Covered until the end of the year in which dependent turns age 26.
Early Retiree Coverage	Not Available
65+ Retiree Coverage	Not Available