

**INDIVIDUAL PLAN**

Your Agreement provides you with important information about your health care benefits, including prior approval requirements. This Schedule of Copayments and Deductibles provides you with information about your costs when you receive health care services and the maximum limitations of your health care benefits. Read the entire Agreement and Schedule of Copayments and Deductibles carefully.

In accordance with the terms and conditions of the Agreement, you are entitled to Covered Services when such services are:

- A. Medically/Clinically Necessary (as defined in the Agreement and according to Medical and Behavioral Health policies established by Priority Health with the input of physicians not employed by Priority Health or according to criteria developed by reputable external sources and adopted by Priority Health); and
- B. Provided by your PCP or provided by a Participating Provider and with approval in advance by us when we consider approval necessary (except in a Medical Emergency) or provided by a Non-participating Provider (one not listed in our Provider Directory) upon referral from your PCP and approved in advance by us (except in a Medical Emergency); and
- C. Not excluded in the Agreement or an amendment to the Agreement.

**If you seek such services without a referral and prior approval when required, you will be responsible for the cost of the services. You will also be responsible for services that are beyond those approved, beyond benefit maximums or excluded from Coverage.**

See Section 6 of your Certificate for Covered and Non-Covered Services, including the summary of Covered Preventive Health Care Services. Priority Health’s complete preventive health care guidelines are available in our Member Center on our website at [priorityhealth.com](http://priorityhealth.com), or you may request a copy from our Customer Service Department.

**DEDUCTIBLE**

The Deductible is the amount of medical Covered Services you must incur during the Contract Year before benefits will be paid.

**Your plan has a Deductible. A Deductible is the amount you must pay before Priority Health will pay for Covered Services under this Certificate. The following services are not subject to the Deductible:**

- **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 as specified on this Schedule of Copayments and Deductibles and on any Riders to the Certificate. However, emergency room services, ambulance services and advanced diagnostic imaging services are subject to the Deductible in addition to a Copayment.**
- **Routine maternity care (the Deductible does apply to facility charges for delivery).**
- **Preventive Health Care Services. See Section 6.A.1 of your Certificate for the summary of Covered Preventive Health Care Services.**

Individual Contract and Family Contract Deductibles:

- If you are the only individual on your contract, you have an Individual Contract and the Individual Contract Deductible below applies.
- If you have more than one individual on your contract, you have a Family Contract and only the Family Contract Deductible applies. The Family Contract Deductible can be satisfied by any one family member or by any combination of family members.

Your Deductible renews each Contract Year.

Notwithstanding the above, your Deductible will not take into account:

- any monies you paid for non-Covered Services; and
- any monies you paid for Covered Services that exceed the annual day, visit or dollar benefit maximum for a specific benefit and therefore, denied as non-Covered Services.

<b>Deductibles</b>	
Individual Contract	\$3,000.00
Family Contract	\$6,000.00 (but not to exceed the Individual Deductible per person)

**OUT OF POCKET MAXIMUMS**

The Out-of-Pocket Maximum applies to certain inpatient and outpatient hospital services and non-hospital facility services. The Out-of-Pocket Maximum limits the total amount of Copayments that you will pay during a Contract Year, except as described below.

<b>Out-of-Pocket Maximums</b>	
Individual	\$2,500.00 per Contract Year
Family	\$5,000.00 per Contract Year (but not to exceed the Individual Out-of-Pocket Maximum per person)

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

- Durable Medical Equipment
- Prosthetic & Orthotic/Support Devices
- Temporomandibular Joint Dysfunction or Syndrome
- Orthognathic Surgery Services
- Family Planning/Infertility Services
- Mental Health Services
- Substance Abuse Services
- Certain Surgeries and Treatments– Physician Fees
- Any flat dollar Copayments, such as Copayments for office visits, ambulance and emergency services.

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

Additionally, your Out-of Pocket Maximum will not take into account:

- any monies you paid for non-Covered Services; and
  - any monies you paid for Covered Services that exceed the annual day/visit or dollar benefit maximum for a specific benefit and therefore, denied as non-Covered Services.
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Services	Benefits
<b>Hospital Services</b> (Including radiology examinations and laboratory services) (See Other Referral Care section below for additional Copayment information)	
<b>Inpatient Hospital and Inpatient Longterm Acute Care Services</b>	<ul style="list-style-type: none"> <li>• 70% Coverage</li> <li>• Prior approval is required except in emergencies or for hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section.</li> <li>• The Out-of-Pocket Maximum applies to these services</li> <li>• Deductible applies</li> </ul>
<b>Outpatient Hospital Services</b> (Including ambulatory surgery center facility charges)	<ul style="list-style-type: none"> <li>• 70% Coverage</li> <li>• The Out-of-Pocket Maximum applies to these services</li> <li>• Prior approval is required for certain radiology examinations</li> <li>• Deductible applies</li> </ul>
<b>Medical Emergency and Urgent Care Services</b>	
<b>Emergency Room Services</b>	<ul style="list-style-type: none"> <li>• \$150.00 Copayment per visit (Copayment waived only if you become confined in a Hospital as an inpatient)</li> <li>• Deductible applies</li> </ul>
<b>Urgent Care Facility Services</b>	<ul style="list-style-type: none"> <li>• \$75.00 Copayment per visit (Copayment applies to all Urgent Care visits)</li> <li>• Deductible does <i>not</i> apply</li> </ul>
<b>Ambulance Services</b>	<ul style="list-style-type: none"> <li>• \$150.00 Copayment</li> <li>• Deductible applies</li> </ul>
<b>Physician Services (Primary and Referral Care)</b> (See Other Referral Care section below for additional Copayment information)	
<b>Office/Home Visits and Consultations</b> (face-to-face, telephonic, or through secure electronic portal by PCP, other Participating Physician and Referral)  -Includes visits <i>not</i> Covered under Preventive Health Care Services or routine maternity services	<ul style="list-style-type: none"> <li>• \$40.00 Copayment per PCP visit</li> <li>• \$55.00 Copayment per other Participating Physician visit, including Specialist Provider</li> <li>• Prescription drug Copayments may also apply when selected injectable drugs are provided</li> <li>• Deductible does <i>not</i> apply</li> </ul>
<b>Preventive Health Care Services</b> - See Section 6.A.1 of your Certificate for the summary of Covered Preventive Health Care Services.	<ul style="list-style-type: none"> <li>• Covered in full</li> <li>• (Office visit copayment may apply)</li> <li>• Deductible does <i>not</i> apply</li> </ul>
<b>Maternity Services</b> (Prenatal and postnatal)	<ul style="list-style-type: none"> <li>• \$40.00 Copayment per visit up to a maximum of four Copayments per pregnancy for routine prenatal and postnatal services only. Attendance at an approved maternity education program is Covered with one PCP office visit Copayment.</li> <li>• Deductible does <i>not</i> apply</li> </ul>
<b>Inpatient Hospital Visits</b>	<ul style="list-style-type: none"> <li>• 70% Coverage</li> <li>• Deductible applies</li> </ul>
<b>Surgery</b>	<ul style="list-style-type: none"> <li>• 70% Coverage</li> <li>• Deductible applies</li> </ul>
<b>Ambulatory Surgery Center Services</b>	<ul style="list-style-type: none"> <li>• Physician surgical services Covered in full in a hospital surgery center.</li> <li>• Deductible applies</li> </ul>

Services	Benefits
Vasectomy	<ul style="list-style-type: none"> <li>• Physician services Covered at 100% only when performed in physician's office or when in connection with other Covered inpatient or outpatient surgery. Deductible applies.</li> <li>• 70% Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery. Deductible applies.</li> </ul>
<b>Tubal Ligation</b>	<ul style="list-style-type: none"> <li>• Physician services Covered at 100%. Deductible applies.</li> <li>• 70% Coverage for outpatient facility charges. Deductible applies.</li> <li>• 70% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery. Deductible applies.</li> </ul>
<b>Allergy Testing and Serum</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Deductible applies</li> </ul>
<b>Allergy Injections</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Deductible applies</li> </ul>
<b>Other Referral Care</b> (Copayments are for all medical services including, but not limited to, physician and hospital services)	
<b>Family Planning/Infertility Services (Limited Coverage)</b>	<ul style="list-style-type: none"> <li>• 50% Coverage for diagnostic, counseling and planning services for treatment of the underlying cause of infertility (Prescription drugs for infertility treatment are not Covered)</li> <li>• Deductible applies</li> </ul>
<b>Temporomandibular Joint Dysfunction or Syndrome</b>	<ul style="list-style-type: none"> <li>• 50% Coverage</li> <li>• Deductible applies</li> </ul>
<b>Orthognathic Surgery</b>	<ul style="list-style-type: none"> <li>• 50% Coverage</li> <li>• Deductible applies</li> </ul>
<b>Certain Surgeries and Treatments (Physician fees only)</b> <ul style="list-style-type: none"> <li>• <i>Bariatric surgery</i></li> <li>• Reconstructive surgery               <ul style="list-style-type: none"> <li>○ Blepharoplasty of upper lids</li> <li>○ Breast reduction</li> <li>○ <i>Panniculectomy</i></li> <li>○ <i>Rhinoplasty</i></li> <li>○ <i>Septorhinoplasty</i></li> <li>○ Surgical treatment of male gynecomastia</li> </ul> </li> <li>• Skin disorder treatments               <ul style="list-style-type: none"> <li>○ Scar revisions</li> <li>○ Keloid scar treatment</li> <li>○ Treatment of hyperhidrosis</li> <li>○ Excision of lipomas</li> <li>○ Excision of seborrheic keratoses</li> <li>○ Excision of skin tags</li> <li>○ Treatment of vitiligo</li> <li>○ Port wine stain and hemangioma treatment</li> </ul> </li> <li>• Varicose veins treatments</li> <li>• Sleep apnea treatment procedures</li> </ul>	<ul style="list-style-type: none"> <li>• Physician fees are Covered at 50% of the first \$2,500.00 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. <i>Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty.</i> Coverage is limited to one bariatric surgery per lifetime unless Medically/Clinically Necessary to correct or reverse complications from a previous bariatric procedure.</li> <li>• Deductible applies</li> </ul>

Services	Benefits
<b>Dietitian Services</b> -Includes visits <i>not</i> Covered under Preventive Health Care Services	\$45.00 Copayment per visit up to 6 visits per Contract Year*
<b>Behavioral Health Services</b> Prior approval by our Behavioral Health Department is required as noted. Call 616 464-8500 or 800 673-8043	
<b>Mental Health Inpatient</b> (Including partial hospitalization)	<ul style="list-style-type: none"> <li>• 70% Coverage up to 20 days per Contract Year * (Two partial hospitalization days count as one inpatient day)</li> <li>• Except in an emergency, prior approval required</li> <li>• Deductible applies</li> </ul>
<b>Mental Health Outpatient</b>	<ul style="list-style-type: none"> <li>• \$40.00 Copayment per visit up to 20 visits per Contract Year* (\$20.00 Copayment per group therapy visit – Two group therapy visits count as one outpatient visit)</li> <li>• Deductible does <i>not</i> apply</li> </ul>
<b>Substance Abuse Care</b> (Including subacute, intermediate care, and outpatient evaluation/therapy)	<ul style="list-style-type: none"> <li>• 70% Coverage up to the minimum annual benefit of \$3,905.00**</li> <li>• Except in an emergency, prior approval required for subacute and partial hospitalization services</li> <li>• Deductible applies</li> </ul>
<b>Rehabilitative Medicine Services</b>	
<ul style="list-style-type: none"> <li>• <b>Physical and Occupational Therapy</b> (including osteopathic and chiropractic manipulation)</li> <li>• <b>Speech Therapy</b></li> <li>• <b>Cardiac Rehabilitation and Pulmonary Rehabilitation</b></li> </ul>	<ul style="list-style-type: none"> <li>• \$40.00 Copayment per visit up to a combined rehabilitative medicine services benefit maximum of 30 visits per Contract year*</li> <li>• Deductible does <i>not</i> apply</li> </ul>
<b>Other Services</b>	
<b>Advanced Diagnostic Imaging Services</b> (such as CT, CTA, MRI, MRA, Nuclear Cardiology Studies, PET Scan)	<ul style="list-style-type: none"> <li>• \$150.00 Copayment (Copayment waived if performed while confined in a Hospital as an inpatient)</li> <li>• Maximum 10 Copayments per individual per Contract year for advanced imaging services.</li> <li>• Prior approval is required for certain radiology examinations</li> </ul>
<b>Standard Radiology Examinations and Laboratory Procedures</b> (In a non-hospital facility or physician's office)	<ul style="list-style-type: none"> <li>• Covered in full if Preventive Health Care Service under Priority Health's preventive health care guidelines</li> <li>• Appropriate office visit Copayment (PCP or other Participating Physician) may apply for physician office services</li> <li>• 70% Coverage if billed by a Participating Provider other than a physician's office. Deductible applies.</li> </ul>
<b>Prosthetic and Orthotic/Support Devices</b>	<ul style="list-style-type: none"> <li>• 50% Coverage</li> <li>• Prior approval required for devices over \$1,000.00</li> <li>• Deductible applies.</li> </ul>
<b>Durable Medical Equipment</b> (Rent, purchase or repair)	<ul style="list-style-type: none"> <li>• 50% Coverage</li> <li>• Prior approval required for equipment over \$1,000.00</li> <li>• Deductible applies</li> </ul>

Services	Benefits
<p><b>Non-Hospital Facility Services</b> Including skilled nursing services received in a:</p> <ul style="list-style-type: none"> <li>• Skilled Nursing Facility</li> <li>• Subacute Facility</li> <li>• Inpatient Rehabilitation Facility</li> <li>• Hospice Facility</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage up to the combined benefit maximum of 45 days per Contract Year*</li> <li>• The Out-of-Pocket Maximum applies to these services</li> <li>• Prior approval required</li> <li>• Deductible applies</li> </ul>
<p><b>Home Health Care</b> (Including Hospice Services, excluding Rehabilitative Medicine)</p> <p><b>Note:</b> Rehabilitative services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described above.</p>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Prior approval required except for hospice services in the home</li> <li>• Deductible applies</li> </ul>

**MAXIMUM LIMITATIONS**

**A. Benefit Maximums:**

\* **Benefit Maximums:** Benefit maximums up to a certain number of days/visits per Contract Year apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

\*\* **Substance Abuse:** Coverage is provided up to a minimum annual benefit as determined by the State of Michigan per Contract Year. Coverage amount to be adjusted each March 31<sup>st</sup> in accordance with the average percentage increase in the “Consumer Price Index for All Urban Consumer-Revised” (CCPI).

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