

**PRIORITY HEALTH**  
**priorityhealth.com**  
**PRIORITYHMO<sup>SM</sup> SUMMARY OF BENEFITS 100% HOSPITAL PLAN**  
**State of Michigan**  
**10/2/11 – 10/1/12**

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 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

**Basic Benefits**

<b>Physician's Services</b>	
Primary Care Provider (PCP) Office Visit (face-to-face, telephonic or through secure electronic portal services provided by a PCP and other Participating Physician 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)	\$10 Copayment per visit
Specialist Office Visit (referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary)	\$10 Copayment per visit
Routine Pre and Post-natal Care	\$10 Copayment per visit. Maximum Copayment of \$60 per pregnancy.
Allergy Care	100% Coverage for injections and serum. Applicable office visit Copayment may apply for testing.
<b>Outpatient Services</b>	
Diagnostic Laboratory and X-Ray	100% Coverage
Chemotherapy	100% Coverage
Radiation Therapy	100% Coverage
Hemodialysis	100% Coverage
<b>Rehabilitative Medicine Services</b>	
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation)	\$10 Copayment up to a benefit maximum of 30 visits per Contract Year.
Speech Therapy	\$10 Copayment up to a benefit maximum of 30 visits per Contract Year.
Cardiac Rehabilitation and Pulmonary Rehabilitation	\$10 Copayment up to a benefit maximum of 30 visits per Contract Year.

**Note: If the above outpatient services are performed and processed in a physician's office, the office visit Copayment applies.**

<b>Hospital Services</b>	
Inpatient Services (semi-private room and intensive care, surgery and all related surgical services, ancillary services while inpatient) <b>Note:</b> Non-emergency inpatient hospital admissions, other than for normal labor and delivery, must be approved in advance by Priority Health.	100% Coverage
Inpatient Hospital Professional Services	100% Coverage
Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services)	100% Coverage Prior approval is required for certain radiology examinations.
Outpatient Hospital Professional Services	100% Coverage

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<b>Hospital Services (continued)</b>	
<b>Certain Surgeries and Treatments (Physician fees only)</b> Bariatric surgery* (limit one per lifetime) Reconstructive surgery: blepharoplasty of upper lids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty* and surgical treatment of male gynecomastia <b>Skin Disorder Treatments:</b> 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*	100% Coverage  *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures.
<b>Emergency Medical Care (in or out of the service area)</b>	
Hospital Emergency Room	\$50 Copayment per visit (waived if admitted)
Urgent Care Center	\$10 Copayment per visit
Physician's Office	\$10 Copayment per visit
Ambulance (land or air)	100% Coverage
<b>Family Planning/Infertility Services</b>	
Vasectomy	100% Coverage when performed in a provider's office or when in connection with other covered inpatient or outpatient surgery.
Tubal Ligation	
Professional Fees	100% Coverage
Outpatient	100% Coverage
Inpatient	100% Coverage only when performed in connection with delivery or other covered inpatient surgery.
Infertility services for diagnostic, counseling and planning services for treatment of the underlying cause of infertility	100% Coverage. Prescription drugs for infertility treatment covered only with prescription drug rider. Office Copayment Applies.
<b>Behavioral Health Services</b>	
<b>Note:</b> Contact Priority Health's Behavioral Health Department at 616 464-8500 or 800 673-8043 if you have questions about your Mental Health or Substance Abuse benefits or coverage.	
Inpatient Mental Health & Substance Abuse Services (including rehabilitation and partial hospitalization)	100% Coverage. Prior approval required
Outpatient Mental Health & Substance Abuse Services (including medication management visits)	\$10 Copayment per visit.
<b>Other Services</b>	
Durable Medical Equipment	100% Coverage
Prosthetics & Orthotics	100% Coverage
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	100% Coverage. Maximum 730 days per confinement (combined benefit for all services).
Home Health Care (including Hospice Services, excluding Rehabilitative Medicine)	Covered in full.
Temporomandibular Joint Syndrome (TMJS)	50% Coverage
Orthognathic Surgery	50% Coverage
Hearing Care	One hearing exam, one audiometric exam and one basic hearing aid per ear every 36 months. Hearing and audiometric exams covered in full. Hearing aid covered in full to a maximum of \$500 per hearing aid.

<b>Additional Benefits</b>	
<b>Pharmacy Services</b>	
Prescription Drugs <b>Note:</b> Prescription drug coverage is based on the usage of a medication formulary.	Covered with a \$5 Generic/\$10 Brand Name Copayment per prescription. Includes contraceptive medications. Infertility drugs covered at 100%. (Limitations apply) 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.
<b>Prescription Mail Order</b> Filled for up to 90 days	Prescription drugs filled for up to 90 days with a \$10 Generic/\$20 Brand Name Copayment per prescription. (Limitations apply)
Prescription Drugs for Sexual Dysfunction	Covered at same copay as above per prescription drug for sexual dysfunction. (Limitations apply)
<b>Eligibility Information</b>	
Dependent Children	Covered up to age 26
Retiree Coverage	Available