#### **PRIORITY HEALTH**

## www.priorityhealth.com/mpsers PRIORITYHMO<sup>SM</sup> PLUS PLAN

MICHIGAN PUBLIC SCHOOL EMPLOYEES RETIREMENT SYSTEM (MPSERS) Effective January 1, 2023 through December 31, 2023

The HMO Plus plan offers you a choice of two benefit levels. The **HMO 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 \***Travel Benefit** level is designed to extend benefits while you are traveling outside of the Priority Health Service Area but within the United States. 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 HMO Plus 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 online at <a href="mailto:priorityhealth.com">priorityhealth.com</a>. Contact Priority Health's Customer Service Department if you have questions about your benefits or coverage.

Copayment = Member pays

% Coverage = Priority Health pays

Deductible	.HMO Plus Benefit – 90/10% Plan	*Travel 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 HMO Plus Benefit Level do not apply toward the Travel Benefit Level deductible	The Deductible is applicable to all covered services except for flat dollar Copayment services.	The Deductible is applicable to all covered services.
and vice versa.		
Individual Deductible per Contract Year	<sub>-</sub> \$750	.\$1,500
Family Deductible per Contract Year	<b>\$1,500</b>	<b>.\$3,000</b>

**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	.HMO Plus Benefit – 90/10% Plan	Travel Benefit – 70/30% Plan
.Note: Out-of-Pocket maximum is the	If the individual out-of-pocket maximum is	All services apply to out-of-pocket
amount of covered expenses that you	reached during a Contract Year, Priority	maximums except Durable Medical
and/or your covered dependents will pay.	Health will pay 100% of covered hospital	Equipment; Prosthetic & Orthotic Devices;
	expenses incurred by that person for the	Treatment of Temporomandibular Joint
Only Coinsurance for inpatient and	rest of the Contract Year. If the family	Syndrome; Orthognathic Surgery
outpatient services applies to out-of-	maximum is reached during a Contract	Services; Family Planning/Infertility
pocket maximum.	Year, Priority Health will pay 100% of covered hospital expenses for you and all	Services; any flat dollar Copayments, such as Copayments for office visits,
Out-of-Pocket maximum amounts	of your covered dependents for the rest of	ambulance and emergency services, Port
satisfied under the HMO Plus Benefit	that Contract Year.	Wine Stains, Certain Surgeries
Level do not apply toward the Travel		Professional Fees and Penalty charges.
Benefit Level deductible and vice versa.		, ,
.Individual Out-of-Pocket Maximum per	.\$5,000	.\$10,000
Contract Year		
.Family Out-of-Pocket Maximum per	.\$10,000	.\$20,000
Contract Year		
.Maximum Individual Lifetime 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 HMO Plus or Travel Benefits up to the limit for one or the other, but not both. (Example: If HMO Plus Benefit is for 60 visits and Travel 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	HMO Plus Benefit – 90/10% Plan	Travel Benefit – 70/30% Plan
	.Deductible applies to all services except where indicated below	Deductible applies to all services
Physician's Services		
Primary Care Provider (PCP) Office Visit (face-to-face, telephonic or through secure electronic portal services provided by your 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)	\$25 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 70%.
Specialist Office Visit (referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary)	\$40 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 and Coinsurance.	70% Coverage of reasonable and customary charges. Lab or X-ray services sent to another facility for analysis covered at 70%.
Routine Pre and Post-natal Care	\$25 Copayment per visit. A maximum of four times the office visit Copayment per pregnancy. Deductible does not apply to routine maternity.	70% Coverage of reasonable and customary charges
Allergy Care	100% Coverage, after deductible, for injections and serum. Applicable office visit Copayment may apply for testing. Deductible does not apply to office visits.	70% Coverage of reasonable and customary charges

Basic Benefits	HMO Plus Benefit – 90/10% Plan	Travel Benefit – 70/30% Plan
Outpatient Services		
Standard Diagnostic Laboratory	90% Coverage. Deductible applies.	70% Coverage of reasonable and
and X-Ray	90% Coverage. Deductible applies.	customary charges
Chemotherapy	90% Coverage. Deductible applies.	
Radiation Therapy	90% Coverage. Deductible applies.	
Hemodialysis		
Note: If the above outpatient services a	re performed and processed in a physici	an's office, only the applicable office
visit Copayment applies.		1
Advanced Diagnostic Imaging	\$150 Copayment per test. Annual	70% Coverage of reasonable and
Includes, but is not limited to the	maximum of 10 Copayments per	customary charges
following: (CT, CTA, MRI, MRA,	individual. (Copayment waived if	Prior approval is required.
Nuclear Cardiology Studies and PET	performed while confined in a	
scanning)	Hospital.) Deductible does not apply	
	to advanced diagnostic imaging.	
	Prior approval is required for certain	
	radiology examinations.	
Rehabilitative Medicine Services		
Physical and Occupational Therapy	\$30 Copayment per visit up to a	50% Coverage of reasonable and
(including osteopathic and	combined benefit maximum of 30	customary charges up to the
chiropractic manipulation)	visits per Contract Year. Deductible	combined benefit maximum of 30
	does not apply.	visits per Contract Year
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Speech Therapy	\$25 Copayment per visit up to a	50% Coverage of reasonable and
	combined benefit maximum of 30	customary charges up to the
	visits per Contract Year. Deductible	combined benefit maximum of 30
Conding Debabilitation and Dulmanan	does not apply.	visits per Contract Year
Cardiac Rehabilitation and Pulmonary	\$25 Copayment per visit up to a	50% Coverage of reasonable and
Rehabilitation	combined benefit maximum of 30	customary charges up to the combined benefit maximum of 30
	visits per Contract Year. Deductible	
Heavital Commisses	does not apply.	visits per Contract Year
Hospital Services	and radiology examinations and laborate	ory coryings)
Inpatient Services	ces, radiology examinations and laborate 90% Coverage. Deductible applies.	70% Coverage of reasonable and
(semi-private room and intensive	90% Coverage. Deductible applies.	customary charges.
care, surgery and all related surgical		Prior approval is required.
services, ancillary services while		Filor approvar is required.
inpatient)		
<b>Note:</b> Non-emergency inpatient		
hospital admissions, other than for		
normal labor and delivery, must be		
approved in advance by Priority Health.		
Inpatient Hospital Professional	90% Coverage. Deductible applies.	70% Coverage of reasonable and
Services	50% Coverage. Deductible applies.	customary charges.
Get vices		Prior approval is required.
Outpatient Surgery at Hospital or	90% Coverage. Deductible applies.	70% Coverage of reasonable and
Ambulatory Center	Prior approval is required for certain	customary charges.
(surgery and all related surgical	radiology examinations.	Prior approval is required.
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Outpatient Hospital Professional	90% Coverage. Deductible applies.	70% Coverage of reasonable and
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keratoses, excision of skin tags, treatment of vitiligo and port wine stain and hemangioma treatment. Varicose veins treatments Siege apnea treatment procedures*  Emergency Medical Care (in or out of the service area)  Hospital Emergency Room  Seo Copayment per visit. (waived if admitted). Deductible does not apply.  Urgent Care Center  Seo Copayment per visit. Deductible does not apply.  Physician's Office  Applicable office visit Copayment per visit. Occayment per visit.  Ambulance (land or air)  Family Planning/Infertility Services (Family Planning and Infertility Services are covered under the HMO Plus Benefit only.)  Vasectomy  Vasectomy  100% Coverage, when performed in a provider's office or 90% Coverage, when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.  Professional Fees  90% Coverage. Deductible applies.  Professional Fees  90% Coverage, when performed in connection with delivery or other covered inpatient surgery. Deductible applies.  Professional Fees  90% Coverage, when performed in connection with delivery or other covered inpatient surgery. Deductible applies.  Inpatient  90% Coverage, when performed in connection with delivery or other covered inpatient surgery. Deductible applies.  Sook Coverage. Deductible applies.  Sook Coverage. Deductible applies.  Prescription drug for infertility treatment covered only with prescription drug rider.  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. Prescription advance by Priority Health's Behavioral Health and Substance Abuse Services (including physicians' advance by Priority Health's Behavioral Advance by Priority Health's Behavioral Health and Substance Abuse Services (including physicians' advance by Priority Health's Behavioral Prescription drug rider.  Professional Fees  90% Coverage Deductible applies.  70% Coverage of reasonable and custom			
treatment of vitiligo and port wine stain and hemangioma treatment. Varicose veins treatments Sleep apnea treatment procedures*  Emergency Medical Care (in or out of the service area)  Hospital Emergency Room  \$150 Copayment per visit (waived if admitted). Deductible does not apply.  For the physician's Office  Physician's Office  Applicable office visit Copayment per visit. Deductible does not apply.  Ambulance (land or air)  \$100 Copayment. Deductible does not apply.  Family Planning/Infertility Services (Family Planning and Infertility Services are covered under the HMO Plus Benefit only.)  Vasectomy  \$100 Coverage, when performed in a provider's office or 90% Coverage, when performed in an provider's office or 90% Coverage, when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.  Professional Fees  \$90% Coverage, Deductible applies.  Professional Fees  \$90% Coverage, When performed in connection with delivery or other covered inpatient surgery. Deductible applies.  Inpatient  \$90% Coverage, Deductible applies.  \$100 Copayment per visit (waived if admitted).  **Admitted)*  *\$100 Copayment per visit.  **Deductible does not apply.  **Not Coverage of reasonable and customary charges  **Professional Inpatient or outpatient or outpatient surgery. Deductible applies.  **Deductible applies.**  **Professional Fees  **90% Coverage, Deductible applies.**  **Professional Fees  \$90% Coverage, Deductible applies.  **Prescription drug rider.**  **Prescription drug rider.**  **Prescription drug for infertility treatment of the underlying cause of infertility reatment covered only with prescription drug rider.**  **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 Services (including priority Health **Substance Abuse Services (including priority Health **Note Coverage of reasonable and customary charges **Note: Contact Priority Health's Behavi			
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Varicose veins treatments Sleep apnea treatment procedures*  Emergency Medical Care (in or out of the service area)  Hospital Emergency Room  S150 Copayment per visit (waived if admitted). Deductible does not apply.  Varient Care Center  S60 Copayment per visit. Deductible does not apply.  Physician's Office  Applicable office visit Copayment applies. Deductible does not apply.  Ambulance (land or air)  Ambulance (land or air)  Family Planning/Infertility Services (Family Planning and Infertility Services are covered under the HMO Plus Benefit only.)  Vasectomy  100% Coverage, when performed in a provider's office or 90% Coverage, when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.  Professional Fees  Outpatient  90% Coverage. Deductible applies.  Inpatient  90% Coverage, when performed in connection with delivery or other covered inpatient surgery. Deductible applies.  Infertility Services for diagnostic, counseling and planning services for treatment of the underlying cause of infertility  Frescription drug rider.  Prescription drug rider.  Pr			
Sleep apnea treatment procedures*   Emergency Medical Care (in or out of the service area)			
Hospital Emergency Room			
admitted). Deductible does not apply.   admitted)	Emergency Medical Care (in or out o	f the service area)	
Urgent Care Center  \$60 Copayment per visit. Deductible does not apply.  Applicable office visit Copayment applies. Deductible does not apply.  Ambulance (land or air)  \$100 Copayment. Deductible does not apply.  Family Planning/Infertility Services (Family Planning and Infertility Services are covered under the HMO Plus Benefit only.)  Vasectomy  \$100% Coverage, when performed in a provider's office or 90% Coverage, when performed in onterconnection with other covered inpatient or outpatient surgery. Deductible applies.  Tubal Ligation  Professional Fees  \$90% Coverage. Deductible applies.  Outpatient  \$90% Coverage, when performed in connection with delivery or other covered inpatient surgery. Deductible applies.  Inpatient  \$90% Coverage, when performed in connection with delivery or other covered inpatient surgery. Deductible applies.  Frescription drugs for infertility treatment of the underlying cause of infertility  Infertility Services for diagnostic, counseling and planning services for treatment of the underlying cause of infertility  Infertility Services (including Physicians' fees and any other related charges)  Sock Coverage. Deductible applies.  Prescription drugs for infertility treatment covered only with prescription drug for infertility treatment covered only with prescription drug for infertility treatment covered only with prescription drug for infertility treatment at 616 464-8500 or 800 673-8043 if you have questions about your Mental Health and Substance Abuse Services (including rehabilitation and partial hospital admissions must be approved in advance by Priority Health's Health and Substance Abuse Services (including rehabilitation and partial hospital admissions must be approved in advance by Priority Health's Health and Substance Abuse Services (including rehabilitation and partial hospital admissions must be approved in advance by Priority Health's Health's Leave of the coverage of reasonable and customary charges and any other related charges)  70% Coverage of reasonable and custom	Hospital Emergency Room	\$150 Copayment per visit (waived if	\$150 Copayment per visit (waived if
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Physician's Office	.Urgent Care Center	\$60 Copayment per visit. Deductible	\$60 Copayment per visit.
Ambulance (land or air)  Ambulance (land or air)  \$100 Copayment. Deductible does not apply.  Family Planning/Infertility Services (Family Planning and Infertility Services are covered under the HMO Plus Benefit only.)  Vasectomy  \$100% Coverage, when performed in a provider's office or 90% Coverage, when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.  Tubal Ligation  Professional Fees  \$90% Coverage. Deductible applies.  Outpatient  \$90% Coverage. Deductible applies.  Inpatient  \$90% Coverage, when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.  Professional Fees  \$90% Coverage. Deductible applies.  \$100 Copayment  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  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 treatment of the underlying cause of infertility  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 benefits or coverage.  Inpatient Mental Health and Substance Abuse benefits or coverage.  Non-emergency inpatient hospital admissions must be approved in advance by Priority Health  \$100 Coverage, when performed in a provide in advance by Priority Health  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related ch		does not apply.	
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Ambulance (land or air)  Family Planning/Infertility Services (Family Planning and Infertility Services are covered under the HMO Plus Benefit only.)  Vasectomy  100% Coverage, when performed in a provider's office or 90% Coverage, when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.  Tubal Ligation  Professional Fees  90% Coverage. Deductible applies.  Outpatient  90% Coverage. Deductible applies.  Inpatient  90% Coverage, when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physi		applies. Deductible does not apply.	
Family Planning/Infertility Services (Family Planning and Infertility Services are covered under the HMO Plus Benefit only.)  Vasectomy  100% Coverage, when performed in a provider's office or 90% Coverage, when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.  Tubal Ligation  Professional Fees  90% Coverage. Deductible applies.  Outpatient  90% Coverage. Deductible applies.  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' f	Ambulance (land or air)		\$100 Copayment
Only.)  Vasectomy  100% Coverage, when performed in a provider's office or 90% Coverage, when performed in a provider's office or 90% Coverage, when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.  Tubal Ligation  Professional Fees  90% Coverage. Deductible applies.  Outpatient  90% Coverage. Deductible applies.  Inpatient  90% Coverage, when performed in connection with delivery or other covered inpatient surgery. Deductible applies.  Infertility Services for diagnostic, counseling and planning services for treatment of the underlying cause of infertility  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. Deductible applies.  Non-emergency inpatient hospital admissions must be approved in avoid the priority Health in advance by Priority Health  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Frescription drugs for infertility treatment covered only with prescription drug rider.  Prescription drug for infertility fees and any other related charges)  Not Coverage of	,	not apply.	
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Inpatient  90% Coverage, when performed in connection with delivery or other covered inpatient surgery. Deductible applies.  Infertility Services for diagnostic, counseling and planning services for treatment of the underlying cause of infertility  Isabel a vioral 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)  90% Coverage, when performed in connection with delivery or other covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)  Not Covered (including physicians' fees and any other related charges)	Outpatient	90% Coverage. Deductible applies.	
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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 Deductible applies.  Substance Abuse Services (including rehabilitation and partial hospitalization)  Non-emergency inpatient hospital admissions must be approved in advance by Priority Health		prescription drug rider.	
about your Mental Health and Substance Abuse benefits or coverage.  Inpatient Mental Health and Substance Abuse Services (including rehabilitation and partial hospitalization)  90% Coverage. Deductible applies. Non-emergency inpatient hospital customary charges  admissions must be approved in advance by Priority Health			
Inpatient Mental Health and Substance Abuse Services (including rehabilitation and partial hospitalization)  90% Coverage. Deductible applies. Non-emergency inpatient hospital customary charges admissions must be approved in advance by Priority Health			
Substance Abuse Services (including rehabilitation and partial hospitalization)  Non-emergency inpatient hospital customary charges admissions must be approved in advance by Priority Health			
rehabilitation and partial admissions must be approved in advance by Priority Health	Inpatient Mental Health and		70% Coverage of reasonable and
hospitalization) advance by Priority Health			customary charges
	rehabilitation and partial	admissions must be approved in	
			70% Coverage of reasonable and
Substance Abuse Services (including   does not apply.   customary charges per visit			
medication management)			- '

Other Services		
.Virtual Visits	100% Coverage at a participating provider.	70% Coverage of reasonable and customary charges
Durable Medical Equipment	80% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Prosthetics & Orthotics	80% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	90% Coverage. Deductible applies. Maximum 100 days per Contract Year. Renewable following sixty (60) days of non-confinement.	70% Coverage of reasonable and customary charges up to 45 days per Contract Year. Prior approval is required.
Home Health Care (including Hospice Services, excluding Rehabilitative Medicine)	90% Coverage. Deductible applies.	70% Coverage of reasonable and customary charges
.Temporomandibular Joint Syndrome (TMJS)	50% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Orthognathic Surgery	50% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Hearing Care	Hearing Exam: Covered in full. One hearing exam, one audiometric exam every 24 months Hearing Aids: \$499 copay per hearing aid for advanced aids, \$799 copay per hearing aid for premium aids. One basic hearing aid per ear every 12 months Exclusively through TruHearing providers	Hearing Exam: Covered in full. One hearing exam, one audiometric exam every 24 months Hearing Aids: \$499 copay per hearing aid for advanced aids, \$799 copay per hearing aid for premium aids. One basic hearing aid per ear every 12 months Exclusively through TruHearing providers

**Note:** Reasonable and Customary Charges – Travel Benefit: Your Travel Benefits will be calculated using the lower billed charges or Reasonable and Customary Charges for such service(s). See your Certificate of Coverage (COC) for details.

Additional Benefits		
Pharmacy Services		
Prescription Drugs 3-tier with Specialty Drug Management	<b>Tier 1- Generic Drugs</b> \$10 Copay per prescription or refill for a Generic Drug	<b>Tier 1- Generic Drugs</b> \$10 Copay per prescription or refill for a Generic Drug
<b>Note:</b> Prescription drug coverage is based on the usage of a medication formulary.	<b>Tier 2- Preferred Brand-Name Drugs</b> \$50 Copay per prescription or refill for a Preferred Brand-Name Drug	<b>Tier 2- Preferred Brand-Name Drugs</b> \$50 Copay per prescription or refill for a Preferred Brand-Name Drug
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.	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 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.
Excludes prescription contraceptive drugs and implantable contraceptive drugs.	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 \$150.00. 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 \$150.00. 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 \$150.00. 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 \$150.00. Subject to Prior Authorization and/or Step Therapy.
	Infertility Treatment 50% Copay for drugs used for treating infertility. (Limitations apply)	Infertility Treatment 50% Copay for drugs used for treating infertility. (Limitations apply)
Prescription Mail Order Filled for up to 90 days	Tier 1- Generic Drugs \$20 Copay per prescription or refill for a Generic Drug	Tier 1- Generic Drugs \$20 Copay per prescription or refill for a Generic Drug
Excludes prescription contraceptive drugs and implantable contraceptive drugs.	Tier 2- Preferred Brand-Name Drugs \$100 Copay per prescription or refill for a Preferred Brand-Name Drug	Tier 2- Preferred Brand-Name Drugs \$100 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 3- Non-Preferred Brand-Name Drugs \$160 Copay per prescription or refill for a Non-Preferred Brand-Name Drug
	Tier 4- Preferred Specialty Drugs Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.	Tier 4- Preferred Specialty Drugs Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.
	Tier 5- Non-Preferred Specialty Drugs Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.	Tier 5- Non-Preferred Specialty Drugs Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.

# Medical Plan Pharmacy Services

# 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.

## Note:

Coverage for outpatient prescription drugs and selected injectable drugs in certain categories is available only if you have a prescription drug benefits.

If your medical plan has a Deductible, the Deductible will apply to Covered medical plan pharmacy services that are detailed in this section.

- 80% Coverage for a preferred Specialty Drug. The maximum Copayment per injection or infusion for a Preferred Specialty Drug is \$150.00
- 80% Coverage for a non-preferred Specialty Drug. The maximum Copayment per injection or infusion for a nonpreferred Specialty Drug is \$150.00
- Copayments for specialty drugs covered under the medical plan benefits will count only towards the specialty drugs maximum copayment amount described in this Medical Plan Pharmacy Services section.
- Prior approval required
- Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy.

Basic Benefits	HMO Plus - 90/10% Plan	Travel Benefit - 70/30% Plan	
	Eligibility Information		
Dependent Children	Covered until the end of the year in which dependent turns age 19. Additionally, covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or the end of the year in which the dependent turns age of 25.	Covered until the end of the year in which dependent turns age 19. Additionally, covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or the end of the year in which the dependent turns age of 25.	
Sponsored Dependent	Coverage for eligible dependents (as defined by group) who are legally related to subscriber and reside with subscriber, and who are not eligible for Medicare or Medicaid.	.Coverage for eligible dependents (as defined by group) who are legally related to subscriber and reside with subscriber, and who are not eligible for Medicare or Medicaid.	
Surviving Spouse and Dependents	Continuation of coverage for surviving spouse and dependents, if elected by surviving spouse.	Continuation of coverage for surviving spouse and dependents, if elected by surviving spouse.	