PRIORITY HEALTH
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PRIORITYHMO℠ SUMMARY OF BENEFITS 100% HOSPITAL PLAN
State of Michigan
10/4/09 – 10/3/10

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

Physician's Services	
Primary Care Provider (PCP) Office Visit (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.
Outpatient Services Diagnostic Laboratory and X-Ray Chemotherapy Radiation Therapy Hemodialysis	 100% Coverage 100% Coverage 100% Coverage 100% Coverage
Rehabilitative Medicine Services	
Physical and Occupational Therapy (including spinal manipulation)	$10 Copayment up to a benefit maximum of 30 visits per Contract Year. Deductible applies.
Speech Therapy	$10 Copayment up to a benefit maximum of 30 visits per Contract Year. Deductible applies.
Cardiac Rehabilitation and Pulmonary Rehabilitation	$10 Copayment up to a benefit maximum of 30 visits per Contract Year. Deductible applies.

Note: If the above outpatient services are performed and processed in a physician's office, the 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
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

SUMMARY OF BENEFITS HMO 100% HOSPITAL PLAN

Hospital Services (continued)	
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*	100% coverage *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and sleep apnea treatment procedures.
Emergency Medical Care (in or out of the service area)	
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
Family Planning/Infertility Services	
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 counseling and treatment of underlying cause of infertility	100% Coverage facility and Prescription drugs. $10 Copayment per visit for physician services.
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	100% Coverage. Maximum 45 days per Contract Year.
Outpatient Mental Health Services	$10 Copayment. Maximum 20 visits per Contract Year.
Substance Abuse Inpatient Days	100% Coverage. Maximum of 45 inpatient days.
Substance Abuse Outpatient Visits	$10 Copayment. Maximum of 35 outpatient visits or the State of Michigan minimum annual benefit, whichever is greater.
Other Services	
Durable Medical Equipment	100% Coverage
Prosthetics & Orthotics	100% Coverage
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	100% Coverage. Maximum 730 days per Contract Year (combined benefit for all services).
Home Health Care	Covered in full. For rehabilitative therapy provided in the home, refer to Short-Term Rehabilitative services for Copayment information.
Temporomandibular Joint Syndrome (TMJS)	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.

Additional Benefits	
Pharmacy Services	
Prescription Drugs **Note:** 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 with a 100%. (Limitations apply) Excludes 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.
Prescription Mail Order	Prescription drugs filled for up to 90 days with a $5 Generic/$10 Brand Name Copayment per prescription. (Limitations apply)
Prescription Drugs for Sexual Dysfunction	Covered with a $5 Generic/$10 Brand Name Copayment per prescription drug for sexual dysfunction. (Limitations apply)

Eligibility Information	
Dependent Children	Covered until the end of the month 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 reaches the age of 25.
Retiree Coverage	Available