

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 www.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

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):

\$10 Copayment per visit

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): \$10 Copayment per visit

Routine Pre & Post-natal Care: \$10 Copayment per visit.

Maximum Copayment of \$60 per pregnancy.

Allergy Care: 100% Coverage for injections and serum.

\$10 Office Visit Copayment may apply for testing.

Outpatient Services

Diagnostic Laboratory & X-ray: 100% Coverage

Chemotherapy: 100% Coverage

Radiation Therapy: 100% Coverage

Hemodialysis: 100% Coverage

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

Short-term Rehabilitative Services (physical, speech, occupational, pulmonary and cardiac therapy): \$10 Copayment per visit for 60 visits per Contract Year (combined benefit for all therapies listed). Out-of-Pocket Maximum of \$200 per Contract Year for rehab services.

Chiropractic Services: \$10 Copayment per visit up to a maximum of 24 visits per Contract Year.

Hospital Services

Inpatient Services: 100% Coverage

(semi-private room and intensive care, surgery and all related surgical 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.

Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services, professional services): 100% Coverage

Certain Surgeries: (bariatric surgery, blepharoplasty of upper eyelids, breast reduction, panniculectomy, surgical treatment of male gynecomastia and procedures to correct obstructive sleep apnea) 100% Coverage.

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: Covered in full (land or air)

Family Planning/Infertility Services

Vasectomy: 100% Coverage when performed in 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.

Diaphragm: 50% Coverage

Infertility counseling and treatment of underlying cause of infertility:

100% Coverage. Prescription drugs for infertility treatment covered only with prescription drug rider.

Mental Health/Substance Abuse Services

Note: All Mental Health and Substance Abuse services must be approved in advance by Priority Health's Behavioral Health Department at 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 Services: Treatment for Alcohol and Drug Dependency covered in full. (Residential: 45 days, renews 60 days after discharge, Outpatient: 35 visits.) \$10 Copayment applies.

Miscellaneous

Durable Medical Equipment: 100% Coverage

Prosthetics & Orthotics: 100% Coverage

Skilled Nursing, Subacute, Long-Term Acute, Inpatient Rehabilitation and Hospice Facility: 100% Coverage. Maximum 730 days per lifetime (combined benefit for all services).

Private duty Nursing: 100% - no day limit

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

Port Wine Stains: 50% Coverage

Orthognathic Surgery: 50% Coverage

Vision Care: Covered for medical conditions and diseases of the eye.

Hearing Care: Covered for hearing exam and hearing aid (one per ear) once every 36 consecutive months.

Additional Benefits

Pharmacy Services

Prescription Drugs: Covered with \$5 Generic/\$10 Name Brand

Copayment per prescription. Includes contraceptive medications.

Infertility drugs covered with a 50% Copayment. (Limitations apply)

Prescription Mail Order: Prescription drugs filled for up to 90 days with a \$5 Generic/\$10 Name Brand Copayment per prescription. (Limitations apply)

Note: Prescription drug coverage is based on the usage of a medication formulary.

Eligibility Information

Dependent Children: Covered until the end of the month in which dependent turns age 19.

Unmarried college students may be covered until they are no longer an unmarried dependent college student or turn 25, whichever is first.

Retiree Coverage: Available