PriorityHealth
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Priority HMO HSA 100-2 Summary of Benefits
HONEY CREEK COMMUNITY SCHOOL
10/1/2011 - 9/30/2012

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

Deductible

Individual Deductible per Contract Year	$3000
Family Deductible per Contract Year	$6000

A Deductible is the amount of covered expenses you must incur during the Contract Year before benefits will be paid. The Deductible is applicable to all covered services except:

- Routine Maternity Care (the Deductible does apply to facility charges for delivery).
- Preventive health care services.

Individual Contract and Family Contract Deductibles:

- If you are the only individual on your contract, you are an Individual Contract and the Individual Contract Deductible 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.

Deductible amounts you pay are included in your out-of-pocket maximum.

Your Deductible renews each Contract Year.

Maximums

Note: Out-of-Pocket maximum is the amount of covered expenses that you and/or your covered dependents will pay.

If you have an Individual Contract, when calculating your Out-of-Pocket Maximum, we will include all Copayments and Deductibles you paid toward medical Covered Services during a Contract Year. If you have a Family Contract, we will include all Copayments and Deductibles you and your family paid collectively toward medical Covered Services during a Contract Year.

Once the applicable Out-of-Pocket Maximum is met, all further medical Covered Services for that Contract Year will be paid by Priority Health at 100% without requirement of Copayment.

Your Out-of-Pocket Maximum limit renews each Contract Year.

Individual Out-of-Pocket Maximum per Contract Year	$5000
Family Out-of-Pocket Maximum per Contract Year	$10000

SUMMARY OF BENEFITS HMO - HSA 100% HOSPITAL PLAN

Preventive Health Care Services	
A summary of Covered Preventive Health Care Services is contained in your Certificate of Coverage. Priority Health's complete preventive health care guidelines are available in our Member Center on our website at *priorityhealth.com,* or you may request a copy from our Customer Service department.	Services Covered in Full. Deductible does not apply.
Physician's Services.	
Primary Care Provider (PCP) Office Visit	100% Coverage. Deductible applies.
Specialist Office Visit (referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary)	100% Coverage. Deductible applies.
Routine Pre and Post-natal Care	Services Covered in Full. Deductible will only apply to facility and anesthesia charges.
Allergy Care	100% Coverage. Deductible applies.
Outpatient Services Diagnostic Laboratory and X-Ray Chemotherapy Radiation Therapy Hemodialysis	 100% Coverage. Deductible applies. 100% Coverage. Deductible applies. 100% Coverage. Deductible applies. 100% Coverage. Deductible applies.
Advanced Diagnostic Imaging Includes, but is not limited to the following: CT, CTA, MRI, MRA, Nuclear Cardiology Studies and PET scanning	100% Coverage. Deductible applies.
Rehabilitative Medicine Services	
Physical and Occupational Therapy *(includes Spinal Manipulation)*	100% Coverage with a limitation of 30 visits per Contract Year (combined benefit for all therapies listed). Deductible applies.
Speech Therapy	100% Coverage with a limitation of 30 visits per Contract Year. Deductible applies.
Cardiac Rehabilitation and Pulmonary Rehabilitation	100% Coverage with a limitation of 30 visits per Contract Year (combined benefit for all therapies listed). Deductible 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. Deductible applies.
Inpatient Hospital Professional Services	100% Coverage. Deductible applies.
Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services)	100% Coverage. Deductible applies. Prior approval is required for certain radiology examinations.
Outpatient Hospital Professional Services	100% Coverage. Deductible applies.
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.	Physician fees are Covered at 50% of the first $2000 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. Deductible applies. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty.* *Coverage is limited to one bariatric surgery per lifetime unless Medically/Clinically Necessary to correct or reverse complications from a previous bariatric procedure.*

Emergency Medical Care (in or out of the service area)	
Hospital Emergency Room	100% Coverage. Deductible applies.
Urgent Care Center	100% Coverage. Deductible applies.
Physician's Office	100% Coverage. Deductible applies.
Ambulance (land or air)	100% Coverage. Deductible applies.
Family Planning/Infertility Services	
Vasectomy	100% Coverage for physician services. Deductible applies. Coverage limited only to when performed in physician's office or when in connection with other Covered inpatient or outpatient surgery. 100% Coverage for outpatient and inpatient facility charges. Deductible applies. Coverage limited only to when performed in connection with other Covered inpatient or outpatient surgery.
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Professional Fees	100% Coverage. Deductible applies.
Outpatient	100% Coverage. Deductible applies.
Inpatient	100% Coverage only when performed in connection with delivery or other covered inpatient surgery. Deductible applies.
Consultations, pre-operative and post-operative visits	100% Coverage. Deductible applies.
Infertility Counseling and Treatment of Underlying Cause of Infertility	50% Coverage. Deductible applies.
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. Deductible applies. Maximum 20 days per Contract Year.
Outpatient Mental Health Services	100% Coverage with limitations of 20 visits per Contract Year. Deductible applies. (Two group therapy visits count as one outpatient visit.)
Substance Abuse Services	80% Coverage up to the minimum annual benefit as determined by the State of Michigan per Contract Year. Deductible applies.
Other Services	
Durable Medical Equipment	50% Coverage. Deductible applies. Prior approval required for equipment over $1,000.
Prosthetics & Orthotics	50% Coverage. Deductible applies. Prior approval required for equipment over $1,000.
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	100% Coverage. Deductible applies. Maximum 45 days per Contract Year (combined benefit for all services).
Home Health Care	100% Coverage. Deductible applies. For rehabilitative therapy provided in the home, refer to Rehabilitative Medicine services for Copayment information. Prior approval required.
Temporomandibular Joint Syndrome (TMJS)	50% Coverage. Deductible applies.
Orthognathic Surgery	50%Coverage. Deductible applies. Prior approval required.

Additional Benefits	
Pharmacy Services	
Prescription Drugs **Note:** Prescription drug coverage is based on the usage of a medication formulary. **Covered prescription drugs apply toward Deductibles and Out-of-Pocket Maximums.**	Covered with a $20 Generic/$60 Preferred Brand/$80 Non-Preferred Brand/20% Preferred Specialty/20% Non-Preferred Specialty Copayment per prescription after deductible. Includes contraceptive medications and contraceptive devices. Infertility drugs covered with a 50% Copayment. (Limitations apply). Maximum Specialty Copayment of $200 Preferred/ $400 Non-Preferred per prescription.
Prescription Mail Order	Prescription drugs filled for up to 90 days with a $40 Generic/ $120 Preferred Brand/$160 Non-Preferred Brand/20% Preferred Specialty/20% Non-Preferred Specialty Copayment per prescription after deductible.
Eligibility Information	
Dependent Children	Covered until dependent turns age 26.

DEPENDENT COVERAGE REQUIRED NOTICE

Individuals whose coverage ended or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26, are eligible to enroll in this plan. Individuals may enroll during the group's next open enrollment period or within 30 days after the group's next renewal.