

PRIORITY HEALTH
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PRIORITY HMOSM SUMMARY OF BENEFITS, 100% HOSPITAL PLAN
UNIVERSITY OF MICHIGAN
1/1/2008 – 12/31/2008

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 616942-1221 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)	\$15 Copayment per visit
Specialist Office Visit (referral care provided by a Participating Physician other than our PCP and prior approval from Priority Health if necessary)	\$15 Copayment per visit
Routine Pre and Post-natal Care	100% Coverage
Allergy Care	100% Coverage for injection and serum. Applicable office visit Copayment may apply for testing.
Outpatient Services	
Diagnostic Laboratory and X-Ray	100% Coverage
Chemotherapy	100% Coverage
Radiation Therapy	100% Coverage
Hemodialysis	100% Coverage
Rehabilitative Medicine Services	
Physical and Occupational Therapy, Speech therapy, Cardiac Rehabilitation and Pulmonary Rehabilitation	\$15 Copayment up to a benefit maximum of 60 visits per Contract Year in total for all therapies

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 in patient) 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

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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	\$15 Copayment per visit
Physician's Office	\$15 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 Outpatient Inpatient	100% Coverage 100% Coverage 100% Coverage when performed in connection with delivery or other covered inpatient surgery.
Infertility counseling and treatment of underlying cause of infertility	\$15 Copayment Diagnostic services only. Prescription drugs for infertility treatment covered only with prescription drug rider.
Elective Termination	Voluntary termination of pregnancy first trimester. 100% Coverage. Limit of one procedure in any 24 consecutive months.
Mental Health/Substance Abuse Services	
Note: All Mental Health and Substance Abuse services must be approved in advance by our Behavioral Health Department. Call 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	\$15 Copayment per visit. Maximum 25 days per Contract Year
Substance Abuse Services	100% Coverage. Maximum Inpatient limited to 30 days per Contract Year up to the minimum aggregate dollar amount as mandated by the State of Michigan.
Outpatient Substance Abuse	\$15 Copayment per visit, limited to 25 days per Contract Year up to the minimum aggregate dollar amount as mandated by the State of Michigan.
Other Services	
Durable Medical Equipment	100% Coverage
Prosthetics & Orthotics	100% Coverage
Skilled Nursing, Sub acute, Inpatient Rehabilitation and Hospice Facility	100% Coverage. Limited to 730 days for each period of confinement. Renews after 60 consecutive days of non-confinement.
Home Health Care	Covered in full.
Temporomandibular Joint Syndrome (TMJS)	100% Coverage
Orthognathic Surgery	50% Coverage