

**PRIORITY HEALTH**  
**priorityhealth.com**  
**PRIORITYHMO<sup>SM</sup> SUMMARY OF BENEFITS**  
**100% HOSPITAL PLAN**  
**ANN ARBOR PUBLIC SCHOOLS - NON TEACHERS**  
**January 1, 2012 - June 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	Not applicable
Family Deductible per Contract Year	Not applicable

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.

Certain services subject to a flat dollar Copayment, such as services received in or billed from your PCP's office, Specialist Provider's office or Urgent Care Center. However, emergency room services, ambulance services and advanced diagnostic imaging services could be subject to the Deductible in addition to a Copayment as noted below.

Any Deductible amounts satisfied during the ninety (90) days preceding the start of a new Contract Year will carry over into the new Contract Year.

**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

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

If the individual out-of-pocket maximum is reached during a Contract Year, Priority Health will pay 100% of covered hospital expenses incurred by that person for the rest of the Contract Year. If the family maximum is reached during a Contract Year, Priority Health will pay 100% of covered hospital expenses for you and all of your covered dependents for the rest of that Contract Year.

Only Coinsurance for inpatient and outpatient services applies to out-of-pocket maximum. The family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person.

Individual Out-of-Pocket Maximum per Contract Year	Not applicable
Family Out-of-Pocket Maximum per Contract Year	Not applicable

**SUMMARY OF BENEFITS HMO 100% HOSPITAL PLAN**
**Basic Benefits**
**Deductible applies to all services except where indicated below**

<b>Physician's Services</b>	
<b>Preventive Health Services</b>	100% Services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines. Services are not subject to the copay.
Primary Care Provider (PCP) Office Visit  (face-to-face, telephonic or through secure electronic portal services provided by a PCP during an office visit for health maintenance for the diagnosis and treatment of a covered illness or injury)	\$20 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)	\$20 Copayment per visit.
Routine Pre and Post-natal Care	\$20 Copayment per visit. A maximum copayment of \$60 per pregnancy.
Allergy Care	100% Coverage for injections and serum. Applicable office visit Copayment may apply.
<b>Outpatient Services</b>	
Standard Diagnostic Laboratory and 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, only the applicable office visit Copayment applies.	
<b>Radiology Examinations and Laboratory Procedures (In a non-hospital facility)</b>	100% Coverage.  Prior approval is required for certain radiology examinations.
<b>Rehabilitative Medicine Services</b>	
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation)	\$20 Copayment up to a benefit maximum of 50 visits per Contract Year.
Speech Therapy	\$20 Copayment up to a benefit maximum of 50 visits per Contract Year.
Cardiac Rehabilitation and Pulmonary Rehabilitation	\$20 Copayment up to a benefit maximum of 50 visits per Contract Year.

**SUMMARY OF BENEFITS HMO 100% HOSPITAL PLAN**
**Hospital Services**

(Including facility-based physician services, radiology examinations and laboratory services)

<p>Inpatient Services</p> <p>(semi-private room and intensive care, surgery and all related surgical services, ancillary services while inpatient)</p> <p>Note: Non-emergency inpatient hospital admissions, other than for normal labor and delivery, must be approved in advance by Priority Health.</p>	<p>100% Coverage.</p>
<p>Inpatient Hospital Professional Services</p>	<p>100% Coverage.</p>
<p>Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services)</p>	<p>100% Coverage.</p> <p>Prior approval is required for certain radiology examinations.</p>
<p>Outpatient Hospital Professional Services</p>	<p>100% Coverage.</p>
<p><b>Certain Surgeries and Treatments (Physician fees only)</b></p> <p>Bariatric surgery* (limit one per lifetime)</p> <p>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.</p> <p>Reconstructive surgery: blepharoplasty of upper lids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty* and surgical treatment of male gynecomastia</p> <p>Varicose veins treatments</p> <p>Sleep apnea treatment procedures*</p>	<p>100% Coverage. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures.</p>

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Emergency Medical Care (in or out of the service area)	
Hospital Emergency Room	\$50 Copayment per visit (waived if admitted).
Urgent Care Center	\$20 Copayment per visit.
Physician's Office	\$20 Applicable office visit Copayment applies.
Ambulance (land or air)	\$0 Copayment.
Family Planning/Infertility Services	
Vasectomy	100% Coverage when performed in a provider's office. Office visit copay may apply.
	100% Coverage when performed 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 services for diagnostic, counseling and planning services for treatment of the underlying cause of infertility	50% Coverage. Prescription drugs for infertility treatment covered only with prescription drug rider.
Behavioral Health Services	
<b>Note:</b> Contact Priority Health's Behavioral Health Department 616 464-8500 or 800 673-8043 if you have questions about your Mental Health or Substance Abuse benefits or coverage.	
Inpatient Mental Health & Substance Abuse Services (including rehabilitation and partial hospitalization)	100% Coverage. Prior approval required
Outpatient Mental Health & Substance Abuse Services (including medication management visits)	\$20 Copayment per visit

Other Services	
Dietician Services	\$20 Copayment per visit. Up to six visits per Contract Year.
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 (including Hospice Services, excluding Rehabilitative Medicine)	100% Coverage.
Temporomandibular Joint Syndrome (TMJS)	50% Coverage.
Orthognathic Surgery	50% Coverage.
Elective Termination	Voluntary termination of pregnancy in first trimester. 50% Copayment. Limit of one procedure in any 24 consecutive months.

Eligibility Information	
Dependent Children	Covered until the end of the year in which dependent turns age 26.
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.
Other Eligible Adult Coverage	Dependent coverage when two individuals of the same or opposite gender live together in a long-term relationship of indefinite duration with an exclusive mutual commitment similar to that of marriage. Eligibility as determined by Group Specific Rider.

### SUMMARY OF BENEFITS HMO 100% HOSPITAL PLAN

Additional Benefits	
Pharmacy Services	
Prescription Drugs  <b>Note:</b> Prescription drug coverage is based on the usage of a medication formulary.  Approved preventive medication covered 100%  <b>Includes approved medication for Oral and Non-Oral treatment for Sexual Dysfunction - Match Rx Copayment. (Limitations apply)</b>	<p style="text-align: center;"><b>Tier 1-Generic Drugs</b></p> <p>\$10 Copay per prescription or refill for a Generic Drug</p> <p style="text-align: center;"><b>Tier 2-Preferred Brand-Name Drugs</b></p> <p>\$40 Copay per prescription or refill for a Preferred Brand-Name Drug</p> <p style="text-align: center;"><b>Tier 3-Non-Preferred Brand-Name Drugs</b></p> <p>\$40 Copay per prescription or refill for a Non-Preferred Brand-Name Drug. Subject to Prior Authorization and/or Step Therapy.</p> <p style="text-align: center;"><b>Tier 4-Preferred Specialty Drugs</b></p> <p>\$40 Copay for a preferred Specialty Drug. Subject to Prior Authorization and/or Step Therapy.</p> <p style="text-align: center;"><b>Tier 5-Non-Preferred Specialty Drugs</b></p> <p>\$40 Copay for a non-preferred Specialty Drug. Subject to Prior Authorization and/or</p> <p style="text-align: center;"><b>Infertility Treatment</b></p> <p>50% Copay for drugs used for treating infertility. (Limitations apply)</p> <p style="text-align: center;"><b>Contraceptive</b></p>

	<p>Includes 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.</p>
<p><b>Prescription Mail Order</b></p> <p>Filled for up to 90 days</p>	<p style="text-align: center;"><b>SPECIALTY DRUGS COPAYMENT MAXIMUM PER CONTRACT YEAR No Copay Maximum</b></p> <p style="text-align: center;"><b>Tier 1- Generic Drugs</b></p> <p>\$10 Copay per prescription or refill for a Generic Drug</p> <p style="text-align: center;"><b>Tier 2- Preferred Brand-Name Drugs</b></p> <p>\$40 Copay per prescription or refill for a Preferred Brand-Name Drug</p> <p style="text-align: center;"><b>Tier 3- Non-Preferred Brand-Name Drugs</b></p> <p>\$40 Copay per prescription or refill for a Non-Preferred Brand-Name Drug. Subject to Prior Authorization and/or Step Therapy.</p> <p style="text-align: center;"><b>Tier 4- Preferred Specialty Drugs</b></p> <p>\$40 Copay Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.</p> <p style="text-align: center;"><b>Tier 5- Non-Preferred Specialty Drugs</b></p> <p>\$40 Copay Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.</p> <p style="text-align: center;"><b>Contraceptive</b></p> <p>Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply)</p>