

The **HealthbyChoice Incentives HMO** plan is a Consumer Engaged Health plan that offers a choice of two benefit designs, Choice and Standard. The Choice benefit design offers richer benefits to members who meet their **HealthbyChoice Incentives** health requirements. Health requirements for the Choice benefit design include:

- Health Quotient (online health risk assessment)
 - No tobacco use
 - Body Mass Index (BMI) below 30
 - Blood Pressure below 140/90
- Or** reasonable alternative to health requirements:
- Cholesterol test
 - Fasting blood sugar or HbA1c, as appropriate
 - Agree to comply with medical doctor program

Members that do not fulfill **HealthbyChoice Incentives** requirements are eligible for the Standard benefit design.

The following information is provided as a summary of benefits available under your **HealthbyChoice Incentives** plan. This summary is not a substitute for your Certificate of Coverage and Schedule of Copayments. 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 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

Inpatient Copay

The Inpatient Copay is the amount you must pay when admitted to an inpatient treatment facility. Inpatient copay amounts you pay are excluded from any out of pocket maximums.

	Choice		Standard	
	Trinity Health	Priority Health	Trinity Health	Priority Health
Inpatient Copay per Admission (limited to 2 per individual/4 per family)	\$250.00	\$750.00	\$500.00	\$750.00

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

The Family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person.

	Choice		Standard	
	Trinity Health	Priority Health	Trinity Health	Priority Health
Individual Out-of-Pocket per Plan Year	\$0.00	\$1,500.00	\$750.00	\$1,500.00
Family Out-of-Pocket per Plan Year	\$0.00	\$3,000.00	\$1,500.00	\$3,000.00

Basic Benefits

	Choice		Standard	
	Trinity Health	Priority Health	Trinity Health	Priority Health
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)	\$20 Copayment per visit. Lab or X-ray services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines are covered at 100%.	\$20 Copayment per visit. Lab or X-ray services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines are covered at 100%.	\$30 Copayment per visit. Lab or X-ray services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines are covered at 100%. Non-preventive Lab or X-ray services that are not billed by the physician's office are subject to Coinsurance.	\$30 Copayment per visit. Lab or X-ray services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines are covered at 100%. Non-preventive Lab or X-ray services that are not billed by the physician's office are subject to Coinsurance.
Specialist Office Visit (referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary)	\$30 Copayment per visit. Lab or X-ray services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines are covered at 100%.	\$30 Copayment per visit. Lab or X-ray services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines are covered at 100%.	\$40 Copayment per visit. Lab or X-ray services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines are covered at 100%. Non-preventive Lab or X-ray services that are not billed by the specialist's office are subject to Coinsurance.	\$40 Copayment per visit. Lab or X-ray services that are considered preventive care under Priority Health's Preventive Healthcare Guidelines are covered at 100%. Non-preventive Lab or X-ray services that are not billed by the specialist's office are subject to Coinsurance.
Routine Pre and Post-natal Care	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Allergy Care	Covered in full, office visit copay may apply			
Outpatient Services				
Diagnostic Laboratory and X-Ray	100% Coverage.	100% Coverage.	90% Coverage.	90% Coverage.
Chemotherapy	100% Coverage.	100% Coverage.	90% Coverage.	90% Coverage.
Radiation Therapy	100% Coverage.	100% Coverage.	90% Coverage.	90% Coverage.
Hemodialysis	100% Coverage.	100% Coverage.	90% Coverage.	90% Coverage.

Basic Benefits

	Choice	Standard
Advanced Diagnostic Imaging Includes, but is not limited to the following: (CT, CTA, MRI, MRA, Nuclear Cardiology Studies and PET scanning)	\$100 Copayment per occurrence. (Copayment waived if performed while confined in a Hospital.) Prior approval is required for certain radiology examinations. Annual maximum of 10 copayments per individual. Note: Advanced diagnostic imaging tests at inpatient hospital or observation setting will not take a copayment, but will be subject to applicable coinsurance.	\$150 Copayment per occurrence. (Copayment waived if performed while confined in a Hospital.) Prior approval is required for certain radiology examinations. Annual maximum of 10 copayments per individual. Note: Advanced diagnostic imaging tests at inpatient hospital or observation setting will not take a copayment, but will be subject to applicable coinsurance.
Rehabilitative Medicine Services		
Physical and Occupational Therapy (including spinal manipulation)	\$20 Copayment up to a benefit maximum of 30 visits per Plan Year.	\$30 Copayment up to a benefit maximum of 30 visits per Plan Year.
Speech Therapy	\$20 Copayment up to a benefit maximum of 30 visits per Plan Year.	\$30 Copayment up to a benefit maximum of 30 visits per Plan Year.
Cardiac Rehabilitation and Pulmonary Rehabilitation	\$20 Copayment up to a benefit maximum of 30 visits per Plan Year.	\$30 Copayment up to a benefit maximum of 30 visits per Plan Year.
Note: If the above outpatient services are performed and processed in a physician's office, only the applicable office visit Copayment applies.		
Hospital Services (Including facility-based physician services, radiology examinations and laboratory 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.	Trinity Health \$250 Copay.	Trinity Health \$500 Copay per Admission, 90% Coverage thereafter
Inpatient Hospital Professional Services	100% Coverage	90% Coverage
Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services)	Trinity Health 100% Coverage. Prior approval is required for certain radiology examinations.	Trinity Health 90% Coverage Prior approval is required for certain radiology examinations.
	Priority Health 80% Coverage Prior approval is required for certain radiology examinations.	Priority Health 80% Coverage Prior approval is required for certain radiology examinations.

Basic Benefits

	Choice	Standard
<p>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 (Physician fees only): Scar revisions, keloid scar treatment, treatment of hyperhidrosis, excision of lipomas, excision of seborrhoeic keratoses, excision of skin tags, treatment of vitiligo port wine stain and hemangioma treatment. Varicose veins treatments Sleep apnea treatment procedures.*</p>	<p>100% Coverage. If applicable, any hospital services Copayment also applies. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and sleep apnea treatment procedures.</p>	<p>90% Coverage. If applicable, any hospital services Copayment also applies. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and sleep apnea treatment procedures.</p>
Emergency Medical Care (in or out of the service area)		
Hospital Emergency Room	\$75 Copay per visit (waived if admitted)	\$100 Copay per visit (waived if admitted)
Urgent Care Center	\$35 Copay per visit.	\$45 copay per visit
Physician's Office	Applicable office visit Copayment applies.	Applicable office visit Copayment applies.
Ambulance (land or air)	\$75 Copayment.	\$75 Copayment.
Family Planning/Infertility Services		
Vasectomy	Not Covered	Not Covered
Tubal Ligation	Not Covered	Not Covered
Professional Fees	Not Covered	Not Covered
Outpatient	Not Covered	Not Covered
Inpatient	Not Covered	Not Covered
Infertility Counseling and Treatment of Underlying Cause of Infertility	100% Coverage. Prescription drugs for infertility treatment covered only with prescription drug rider.	100% Coverage. Prescription drugs for infertility treatment covered only with prescription drug rider

Basic Benefits

		Choice	Standard
<p>Mental Health/Substance Abuse Services</p> <p>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</p>			
Inpatient Mental Health Services	<p>Trinity Health \$250 copay Maximum 20 days per Plan Year</p>	<p>Priority Health \$750 Copay per Admission, 80% Coverage thereafter Maximum 20days per Plan Year.</p>	<p>Priority Health \$500 Copay per Admission, 90% Coverage thereafter Maximum 20 days per Plan Year.</p>
Outpatient Mental Health Services	<p>Trinity Health \$20 Copayment. Maximum 20 visits per Plan Year.</p>	<p>Priority Health \$750 Copay per Admission, 80% Coverage thereafter Maximum 20 days per Plan Year</p>	<p>Priority Health \$30 Copayment. Maximum 20 visits per Plan Year.</p>
Inpatient Substance Abuse Services	<p>Trinity Health \$250 Copay Maximum 20 days per Plan Year</p>	<p>Priority Health \$750 Copay per Admission, 80% Coverage thereafter Maximum 20 days per Plan Year</p>	<p>Priority Health \$500 Copay per Admission, 90% Coverage thereafter Maximum 20 days per Plan Year</p>
Outpatient Substance Abuse Services	<p>Trinity Health \$20 Copayment up to 20 visits per Plan Year</p>	<p>Priority Health \$30 Copayment up to 20 visits per Plan Year</p>	<p>Priority Health \$30 Copayment up to 20 visits per Plan Year</p>
Other Services			
Dietitian Services	<p>\$30 Copayment per visit. Up to six visits per Plan Year.</p>	<p>\$40 Copayment per visit. Up to six visits per Plan Year.</p>	<p>\$40 Copayment per visit. Up to six visits per Plan Year.</p>
Durable Medical Equipment	<p>50% Coverage.</p>	<p>50% Coverage.</p>	<p>50% Coverage.</p>
Prosthetics & Orthotics	<p>50% Coverage.</p>	<p>50% Coverage.</p>	<p>50% Coverage.</p>
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	<p>100% Coverage. Maximum 45 days per confinement, renews after 60 days (combined benefit for all services).</p>	<p>100% Coverage. Maximum 45 days per confinement, renews after 60 days (combined benefit for all services).</p>	<p>90% Coverage. Maximum 45days per confinement, renews after 60 days (combined benefit for all services).</p>
Home Health Care	<p>\$20 copay</p>	<p>\$30 copay</p>	<p>\$30 copay</p>
Temporomandibular Joint Syndrome (TMJS)	<p>100% Coverage.</p>	<p>100% Coverage.</p>	<p>100% Coverage.</p>
Additional Benefits			
Pharmacy Services			
Prescription Drugs	<p>Covered with a \$10 Generic/\$20 Brand Name/\$40 Non-Formulary Copayment per prescription, 34-day supply. Excludes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply) The pharmacy benefit does not include coverage for the additional cost of Brand Generic Drug is available on the Priority Health formulary. Member will be responsible for the difference in charges between a Brand Drug and Generic Drug when an equivalent Generic Drug is available.</p>	<p>Covered with a \$10 Generic/\$20 Brand Name/\$40 Non-Formulary Copayment per prescription, 34-day supply. Excludes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply) The pharmacy benefit does not include coverage for the additional cost of Brand Priority Health formulary. Member will be responsible for the difference in charges between a Brand Drug and Generic Drug when an equivalent Generic Drug is available.</p>	<p>Covered with a \$10 Generic/\$20 Brand Name/\$40 Non-Formulary Copayment per prescription, 34-day supply. Excludes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply) The pharmacy benefit does not include coverage for the additional cost of Brand Drugs when an equivalent Generic Drug is available on the Priority Health formulary. Member will be responsible for the difference in charges between a Brand Drug and Generic Drug when an equivalent Generic Drug is available.</p>
Prescription Mail Order	<p>Prescription drug coverage is based on the usage of medication formulary.</p>	<p>Prescription drugs filled for up to 90 days with a \$20 Generic/\$40 Brand Name/\$80 Non-Formulary Copayment per prescription. (Limitations apply)</p>	<p>Prescription drugs filled for up to 90 days with a \$20 Generic/\$40 Brand Name/\$80 Non-Formulary Copayment per prescription. (Limitations apply)</p>
<p>Note: Benefits generated are pending subject to final approval by the Office of Financial and Insurance Regulation (OFIR).</p>			