

Summary of Covered Services for Plan 224



As a member, you select a primary care provider from Priority Health HMO directory of participating physicians. Your physician will coordinate every aspect of your health care and may refer you to specialists when necessary.

■ In The Physician's Office

No additional charges for covered services after a copay of \$15 per office visit.

- Periodic physical exams Covered
- Well baby exams..... Covered
- Immunizations..... Covered
- Allergy tests Covered
- Hearing tests and exams Covered
- Minor surgical procedures Covered
- Diagnostic testing..... Covered
- Visit for illness or injury Covered

■ In The Hospital

After a \$500 copay per admission.*

- Unlimited days for semi-private Covered accommodations.
Private room when necessary.
- Physician's medical, surgical, Covered anesthesiology and consultation services
- Use of ICU, CCU and special care units Covered
- Use of operating room Covered
- Newborn nursery care Covered
- Laboratory and X-Ray services Covered
- Physical therapy..... Covered
- Medical and surgical supplies..... Covered
- Drugs and medications Covered

■ As An Outpatient

- Laboratory, pathology and Covered chemotherapy services
- Diagnostic and therapeutic radiology Covered
- Same day surgery Covered
- Physical and..... \$15 copay per visit; occupational therapy up to a benefit maximum of 30 visits per Contract year
- Speech therapy..... \$15 copay per visit; up to a benefit maximum of 30 visits per Contract year
- Cardiac rehabilitation and... ..\$15 copay per visit; pulmonary rehabilitation up to a benefit maximum of 30 visits per Contract year

■ Maternity Care

After a \$500 copay per admission.*

- All physician's services Covered (including pre-natal care and post-partum care visits).

■ Emergency Services

For care received for an emergency condition, in a hospital emergency room or urgent care facility, anywhere in the world.

- Hospital Emergency Room \$50 copay
- Urgent Care Facility. \$25 copay

The copay will be waived if the member is admitted to the hospital. Members must notify Priority Health HMO within 48 hours of an emergency admission to a hospital.

Benefits are accurate at time of printing. Please check with your Benefit Administrator for current benefit levels

■ Mental Health Services

- Up to 30 inpatient days per year..... Covered
- Outpatient servicesUp to 20 visits per year; 50% copay per visit

■ Substance Abuse Services

- Up to 30 days per year at an Covered approved treatment facility
- Outpatient servicesUp to 20 visits per year; 50% copay per visit

■ Prescription Drugs

At participating retail pharmacies..... \$10 Generic/
\$20 Brand Name/\$40 Non-Formulary
Copayment per prescription

Mail order Filled for up to 90 days with a
\$20 Generic/\$40 Brand Name/\$80 Non-Formulary
Copayment per prescription. (Limitations apply)

Excludes prescription contraceptive drugs.

■ Other Services

When medically required and approved by the Plan, or prescribed by a Plan physician.

- Skilled home health services Covered
- Skilled nursing facility Up to 45 days renewable after 60 days
- Durable medical equipment 50% copay
- Prosthetic devices..... 50% copay
- Ambulance services..... Covered
- HospiceUp to 90 days renewable

■ Limitations and Exclusions

- Any service in or out of the hospital not performed, prescribed, arranged or authorized by a Priority Health HMO physician.
- Dental care or oral surgery, except as specifically provided in the Certificate of Coverage and authorized by a Priority Health HMO physician.
- Any services in a government hospital (or available under law)
- Custodial care, bed rest, convenience care
- Eyeglasses, contact lenses, or dentures
- Cosmetic surgery
- Abortion services
- Sterilization procedures
- Personal comfort items and services
- Experimental procedures
- Hearing aids

Note: 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.

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.

*Maximum copay for inpatient care of \$1,000 per member per year/\$2,000 per family per year.