PRIORITY HEALTH
www.priorityhealth.com/mpsers
PRIORITYHMO℠ **PLUS PLAN**
MICHIGAN PUBLIC SCHOOL EMPLOYEES RETIREMENT SYSTEM (MPSERS)
Effective January 1, 2025 through December 31, 2025

The HMO Plus plan offers you a choice of two benefit levels. The **HMO Benefit** level applies when your Primary Care Provider (PCP) or other Participating Physician coordinates all of your medical care. Your out-of-pocket costs are lower when you use this option. The ***Travel Benefit** level is designed to extend benefits while you are traveling outside of the Priority Health Service Area but within the United States. Services you receive that are excluded from coverage are not paid at either benefit level.

The following information is provided as a summary of benefits available under your HMO Plus plan. This summary is not intended as 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 online at prioritythealth.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	**HMO Plus Benefit – 90/10% Plan**	***Travel Benefit – 70/30% Plan**
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. Deductible amounts satisfied under the HMO Plus Benefit Level do not apply toward the Travel Benefit Level deductible and vice versa.	The Deductible is applicable to all covered services except for flat dollar Copayment services.	The Deductible is applicable to all covered services.
Individual Deductible per Contract Year	$750	$1,500
Family Deductible per Contract Year	$1,500	$3,000
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	**HMO Plus Benefit – 90/10% Plan**	**Travel Benefit – 70/30% Plan**
Note: Out-of-Pocket maximum is the amount of covered expenses that you and/or your covered dependents will pay. Only Coinsurance for inpatient and outpatient services applies to out-of-pocket maximum. Out-of-Pocket maximum amounts satisfied under the HMO Plus Benefit Level do not apply toward the Travel Benefit Level deductible and vice versa.	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. .	All services apply to out-of-pocket maximums except Durable Medical Equipment; Prosthetic & Orthotic Devices; Treatment of Temporomandibular Joint Syndrome; Orthognathic Surgery Services; Family Planning/Infertility Services; any flat dollar Copayments, such as Copayments for office visits, ambulance and emergency services, Port Wine Stains, Certain Surgeries Professional Fees and Penalty charges.
Individual Out-of-Pocket Maximum per Contract Year	$5,000	$10,000
Family Out-of-Pocket Maximum per Contract Year	$10,000	$20,000
Maximum Individual Lifetime Benefit	Not Applicable	$1,000,000
Note: Priority Health Benefit Maximum: Coverage maximums up to a certain number of days/visits per Contract Year are reached by combining either HMO Plus or Travel Benefits up to the limit for one or the other, but not both. (Example: If HMO Plus Benefit is for 60 visits and Travel Benefit is for 60 visits, the maximum benefit is 60 visits, not 120 visits). The Family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person.		

Basic Benefits	HMO Plus Benefit – 90/10% Plan	Travel Benefit – 70/30% Plan
	Deductible applies to all services except where indicated below	Deductible applies to all services
Physician's Services		
Primary Care Provider (PCP) Office Visit (face-to-face, telephonic or through secure electronic portal services provided by your PCP 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)	$25 Copayment per visit. Deductible does not apply to PCP visits. 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 Deductible and Coinsurance.	70% Coverage of reasonable and customary charges for face-to-face visits only. Lab or X-ray services sent to another facility for analysis covered at 70%.
Specialist Office Visit (referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary)	$40 Copayment per visit. Deductible does not apply to specialist visits. 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 Deductible and Coinsurance.	70% Coverage of reasonable and customary charges. Lab or X-ray services sent to another facility for analysis covered at 70%.
Routine Pre and Post-natal Care	$25 Copayment per visit. A maximum of four times the office visit Copayment per pregnancy. Deductible does not apply to routine maternity.	70% Coverage of reasonable and customary charges
Allergy Care	100% Coverage, after deductible, for injections and serum. Applicable office visit Copayment may apply for testing. Deductible does not apply to office visits.	70% Coverage of reasonable and customary charges

Basic Benefits	HMO Plus Benefit – 90/10% Plan	Travel Benefit – 70/30% Plan
Outpatient Services Standard Diagnostic Laboratory and X-Ray Chemotherapy Radiation Therapy Hemodialysis	 90% Coverage. Deductible applies. 90% Coverage. Deductible applies. 90% Coverage. Deductible applies. 90% Coverage. Deductible applies.	 70% Coverage of reasonable and customary charges
Note: If the above outpatient services are performed and processed in a physician's office, only the applicable office visit Copayment applies.		
Advanced Diagnostic Imaging Includes, but is not limited to the following: (CT, CTA, MRI, MRA, Nuclear Cardiology Studies and PET scanning)	$150 Copayment per test. Annual maximum of 10 Copayments per individual. (Copayment waived if performed while confined in a Hospital.) Deductible does not apply to advanced diagnostic imaging. Prior approval is required for certain radiology examinations.	70% Coverage of reasonable and customary charges Prior approval is required.
Rehabilitative Medicine Services		
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation)	$30 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year. Deductible does not apply.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 30 visits per Contract Year
Speech Therapy	$25 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year. Deductible does not apply.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 30 visits per Contract Year
Cardiac Rehabilitation and Pulmonary Rehabilitation	$25 Copayment per visit up to a combined benefit maximum of 30 visits per Contract Year. Deductible does not apply.	50% Coverage of reasonable and customary charges up to the combined benefit maximum of 30 visits per Contract Year
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.	90% Coverage. Deductible applies.	70% Coverage of reasonable and customary charges. Prior approval is required.
Inpatient Hospital Professional Services	90% Coverage. Deductible applies.	70% Coverage of reasonable and customary charges. Prior approval is required.
Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services)	90% Coverage. Deductible applies. Prior approval is required for certain radiology examinations.	70% Coverage of reasonable and customary charges. Prior approval is required.
Outpatient Hospital Professional Services	90% Coverage. Deductible applies.	70% Coverage of reasonable and customary charges. Prior approval is required.

Basic Benefits	HMO Plus Benefit – 90/10% Plan	Travel Benefit – 70/30% Plan
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 $2,000.00 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, septorhinoplasty and sleep apnea treatment procedures.	Physician fees are Covered at 50% of the first $3,000.00 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. Deductible applies. *Prior approval required for bariatrric surgery, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures.
Emergency Medical Care (in or out of the service area)		
Hospital Emergency Room	$150 Copayment per visit (waived if admitted). Deductible does not apply.	$150 Copayment per visit (waived if admitted)
Urgent Care Center	$60 Copayment per visit. Deductible does not apply.	$60 Copayment per visit.
Physician's Office	Applicable office visit Copayment applies. Deductible does not apply.	70% Coverage of reasonable and customary charges
Ambulance (land or air)	$100 Copayment. Deductible does not apply.	$100 Copayment
Family Planning/Infertility Services (Family Planning and Infertility Services are covered under the HMO Plus Benefit only.)		
Vasectomy	100% Coverage, when performed in a provider's office or 90% Coverage, when performed in connection with other covered inpatient or outpatient surgery. Deductible applies.	Not Covered (including physicians' fees and any other related charges)
Tubal Ligation		
Professional Fees	90% Coverage. Deductible applies.	Not Covered (including physicians' fees and any other related charges)
Outpatient	90% Coverage. Deductible applies.	Not Covered (including physicians' fees and any other related charges)
Inpatient	90% Coverage, when performed in connection with delivery or other covered inpatient surgery. Deductible applies.	Not Covered (including physicians' fees and any other related charges)
Infertility Services for diagnostic, counseling and planning services for treatment of the underlying cause of infertility	50% Coverage. Deductible applies. Prescription drugs for infertility treatment covered only with prescription drug rider.	Not Covered (including physicians' fees and any other related charges)
Behavioral Health Services **Note:** Contact Priority Health's Behavioral Health Department at 616 464-8500 or 800 673-8043 if you have questions about your Mental Health and Substance Abuse benefits or coverage.		
Inpatient Mental Health and Substance Abuse Services (including rehabilitation and partial hospitalization)	90% Coverage. Deductible applies. Non-emergency inpatient hospital admissions must be approved in advance by Priority Health	70% Coverage of reasonable and customary charges
Outpatient Mental Health and Substance Abuse Services (including medication management)	$25 Copayment per visit. Deductible does not apply.	70% Coverage of reasonable and customary charges per visit

Other Services		
Virtual Visits	100% Coverage at a participating provider.	70% Coverage of reasonable and customary charges
Durable Medical Equipment	80% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Prosthetics & Orthotics	80% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	90% Coverage. Deductible applies. Maximum 100 days per Contract Year. Renewable following sixty (60) days of non-confinement.	70% Coverage of reasonable and customary charges up to 45 days per Contract Year. Prior approval is required.
Home Health Care (including Hospice Services, excluding Rehabilitative Medicine)	90% Coverage. Deductible applies.	70% Coverage of reasonable and customary charges
Temporomandibular Joint Syndrome (TMJS)	50% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Orthognathic Surgery	50% Coverage. Deductible applies.	50% Coverage of reasonable and customary charges
Hearing Care	Hearing Exam: Covered in full. One hearing exam, one audiometric exam every 24 months Hearing Aids: $499 copay per hearing aid for advanced aids, $799 copay per hearing aid for premium aids. One basic hearing aid per ear every 12 months Exclusively through TruHearing providers	Hearing Exam: Covered in full. One hearing exam, one audiometric exam every 24 months Hearing Aids: $499 copay per hearing aid for advanced aids, $799 copay per hearing aid for premium aids. One basic hearing aid per ear every 12 months Exclusively through TruHearing providers

Note: Reasonable and Customary Charges – Travel Benefit: Your Travel Benefits will be calculated using the lower billed charges or Reasonable and Customary Charges for such service(s). See your Certificate of Coverage (COC) for details.

Additional Benefits		
Pharmacy Services		
Prescription Drugs **3-tier with Specialty Drug Management** **Note:** Prescription drug coverage is based on the usage of a medication formulary. **Drugs Requiring Administration by a Health Professional**: Injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or outpatient facility. Step therapy may be required before drug will be Covered. Excludes prescription contraceptive drugs and implantable contraceptive drugs.	**Tier 1- Generic Drugs** $10 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $50 Copay per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** $80 Copay per prescription or refill for a Non-Preferred Brand-Name Drug. Subject to Prior Authorization and/or Step Therapy. **Tier 4- Preferred Specialty Drugs** 20% Copayment for a preferred Specialty Drug. The maximum Copayment per prescription or refill for a preferred Specialty Drug is $150.00. Subject to Prior Authorization and/or Step Therapy. **Tier 5- Non-Preferred Specialty Drugs** 20% Copayment for a non-preferred Specialty Drug. The maximum Copayment per prescription or refill for a non-preferred Specialty Drug is $150.00. Subject to Prior Authorization and/or Step Therapy. **Infertility Treatment** 50% Copay for drugs used for treating infertility. (Limitations apply)	**Tier 1- Generic Drugs** $10 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $50 Copay per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** $80 Copay per prescription or refill for a Non-Preferred Brand-Name Drug. Subject to Prior Authorization and/or Step Therapy. **Tier 4- Preferred Specialty Drugs** 20% Copayment for a preferred Specialty Drug. The maximum Copayment per prescription or refill for a preferred Specialty Drug is $150.00. Subject to Prior Authorization and/or Step Therapy. **Tier 5- Non-Preferred Specialty Drugs** 20% Copayment for a non-preferred Specialty Drug. The maximum Copayment per prescription or refill for a non-preferred Specialty Drug is $150.00. Subject to Prior Authorization and/or Step Therapy. **Infertility Treatment** 50% Copay for drugs used for treating infertility. (Limitations apply)
Prescription Mail Order Filled for up to 90 days Excludes prescription contraceptive drugs and implantable contraceptive drugs.	**Tier 1- Generic Drugs** $20 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $100 Copay per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** $160 Copay per prescription or refill for a Non-Preferred Brand-Name Drug **Tier 4- Preferred Specialty Drugs** Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. **Tier 5- Non-Preferred Specialty Drugs** Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.	**Tier 1- Generic Drugs** $20 Copay per prescription or refill for a Generic Drug **Tier 2- Preferred Brand-Name Drugs** $100 Copay per prescription or refill for a Preferred Brand-Name Drug **Tier 3- Non-Preferred Brand-Name Drugs** $160 Copay per prescription or refill for a Non-Preferred Brand-Name Drug **Tier 4- Preferred Specialty Drugs** Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill. **Tier 5- Non-Preferred Specialty Drugs** Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.

Medical Plan Pharmacy Services	
Drugs Requiring Administration by a Health Professional (injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or outpatient facility) Step therapy may be required before drug will be covered. **Note:** Coverage for outpatient prescription drugs and selected injectable drugs in certain categories is available only if you have a prescription drug benefits. If your medical plan has a Deductible, the Deductible will apply to Covered medical plan pharmacy services that are detailed in this section.	• 80% Coverage for a preferred Specialty Drug. The maximum Copayment per injection or infusion for a Preferred Specialty Drug is $150.00 • 80% Coverage for a non-preferred Specialty Drug. The maximum Copayment per injection or infusion for a non-preferred Specialty Drug is $150.00 • Copayments for specialty drugs covered under the medical plan benefits will count only towards the specialty drugs maximum copayment amount described in this Medical Plan Pharmacy Services section. • Prior approval required • Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy.

Basic Benefits	HMO Plus – 90/10% Plan	Travel Benefit – 70/30% Plan
Eligibility Information		
Dependent Children	Covered until the end of the year in which dependent turns age 19. Additionally, covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or the end of the year in which the dependent turns age of 25.	Covered until the end of the year in which dependent turns age 19. Additionally, covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or the end of the year in which the dependent turns age of 25.
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.	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.
Surviving Spouse and Dependents	Continuation of coverage for surviving spouse and dependents, if elected by surviving spouse.	Continuation of coverage for surviving spouse and dependents, if elected by surviving spouse.