

PriorityHealth
priorityhealth.com
PriorityHRA - HMO Summary of Benefits 80/20% Hospital Plan
WOODLAND SCHOOL
1/1/2010 - 12/31/2010

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. This summary is in addition to the Summary Plan Description (SPD). **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	\$3,000
Family Deductible per Contract Year	\$6,000

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. The Deductible is applicable to all covered services except flat dollar Copayment services.

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.

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	\$1,500
Family Out-of-Pocket Maximum per Contract Year	\$3,000

Basic Benefits

Deductible applies to all services except where indicated below

Preventive Health Care Services	
When services listed in Priority Health's Preventive Health Care Guidelines are considered preventive by the physician, services are covered in full. The deductible does not apply. When the physician considers any service diagnostic, the deductible will apply.	Services Covered in Full. Deductible does not apply. Office visit copayment applies.
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)	\$30 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 Health Care 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.
Specialist Office Visit (referral care provided by a Participating Physician other than your PCP and prior approval from Priority Health if necessary)	\$45 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 Health Care 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.
Routine Pre and Post-natal Care	\$30 Copayment per visit. A maximum of four times the office visit Copayment per pregnancy. (Deductible does not apply to routine maternity)

SUMMARY OF BENEFITS HRA - HMO 80/20% HOSPITAL PLAN

Allergy Care	100% Coverage for injections and serum. Applicable office visit Copayment may apply for testing. Deductible does not apply to office visits.
Outpatient Services Diagnostic Laboratory and X-Ray Chemotherapy Radiation Therapy Hemodialysis	80% Coverage. Deductible applies. 80% Coverage. Deductible applies. 80% Coverage. Deductible applies. 80% Coverage. Deductible 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 (see note below). Deductible does not apply. 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 with not take a copayment, but will be subject to applicable deductible and/or coinsurance.
Rehabilitative Medicine Services	
Physical and Occupational Therapy (includes Spinal Manipulation)	\$30 Copayment per visit for 30 visits per Contract Year (combined benefit for all therapies listed). Deductible does not apply.
Speech Therapy	\$30 Copayment per visit for 30 visits per Contract Year. Deductible does not apply.
Cardiac Rehabilitation and Pulmonary Rehabilitation	\$30 Copayment per visit for 30 visits per Contract Year (combined benefit for all therapies listed). Deductible does not apply.
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.	80% Coverage. Deductible applies.
Inpatient Hospital Professional Services	80% Coverage. Deductible applies.
Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services)	80% Coverage. Deductible applies. Prior approval is required for certain radiology examinations.
Outpatient Hospital Professional Services	80% Coverage. Deductible applies.
Certain Surgeries and Treatments (Physician fees only) <i>Bariatric surgery</i> (limit one per lifetime) Reconstructive surgery: blepharoplasty of upper lids, breast reduction, <i>panniculectomy, rhinoplasty, septorhinoplasty</i> 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 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. Deductible applies. <i>Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty. Coverage is limited to one bariatric surgery per lifetime unless Medically/Clinically Necessary to correct or reverse complications from a previous bariatric procedure.</i>

SUMMARY OF BENEFITS HRA - HMO 80/20% HOSPITAL PLAN

Emergency Medical Care (in or out of the service area)	
Hospital Emergency Room	\$100 Copayment per visit (waived if admitted). Deductible does not apply.
Urgent Care Center	\$60 Copayment per visit. Deductible does not apply.
Physician's Office	Applicable office visit Copayment applies. Deductible does not apply.
Ambulance (land or air)	\$50 Copayment. Deductible does not apply.
Family Planning/Infertility Services	
Vasectomy	100% Coverage when performed in a provider's office. Deductible applies. 80% Coverage when performed in connection with other Covered inpatient or outpatient surgery. Deductible applies.
Tubal Ligation	
Professional Fees	80% Coverage. Deductible applies.
Outpatient	80% Coverage. Deductible applies.
Inpatient	80% Coverage only when performed in connection with delivery or other covered inpatient surgery. Deductible applies.
Infertility Counseling and Treatment of Underlying Cause of Infertility	50% Coverage. Deductible applies. Prescription drugs for infertility treatment covered only with prescription drug rider.
Mental Health/Substance Abuse Services	
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.	
Inpatient Mental Health Services	80% Coverage. Deductible applies. Maximum 20 days per Contract Year.
Outpatient Mental Health Services	\$20 Copayment. Deductible does not apply. Maximum 20 visits per Contract Year. (\$10 Copayment per group therapy visit - two group therapy visits counts a one outpatient visit.)
Substance Abuse Services	80% Coverage up to the minimum annual benefit as determined by the State of Michigan per Contract Year. Deductible applies.
Other Services	
Dietitian Services	\$45 Copayment per visit. Up to six visits per Contract Year.
Durable Medical Equipment	50% Coverage. Deductible applies.
Prosthetics & Orthotics	50% Coverage. Deductible applies.
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	80% Coverage. Deductible applies. Maximum 45 days per Contract Year (combined benefit for all services).
Home Health Care	Covered in full. Deductible applies. For rehabilitative therapy provided in the home, refer to Rehabilitative Medicine services for Copayment information.
Temporomandibular Joint Syndrome (TMJS)	50% Coverage. Deductible applies.
Orthognathic Surgery	50% Coverage. Deductible applies.
Vision Care Exam Every 12 Consecutive Months	One eye exam (including refraction) with a participating provider every 12 consecutive months. \$15 Copayment. Limitations apply.

SUMMARY OF BENEFITS HRA - HMO 80/20% HOSPITAL PLAN

Additional Benefits	
Pharmacy Services	Medical Deductible does not apply
Prescription Drugs Note: Prescription drug coverage is based on the usage of a medication formulary.	Covered with a \$15 Generic / \$50 Brand Copayment per prescription. 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 and ointments and other drugs or devices available over the counter. Infertility drugs covered with a 50% Copayment. (Limitations apply). No Rx Deductible.
Prescription Mail Order	Prescription drugs filled for up to 90 days with a \$30 Generic / \$100 Brand Copayment per prescription. No Rx Deductible. (Limitations apply).
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 reaches the age of 25.