

**PriorityHealth**  
**priorityhealth.com**  
**Priority HMO Summary of Benefits 100% Hospital Plan**  
**WESTVILLAGE ACADEMY**  
**10/1/2010 - 9/30/2011**

The following information is provided as a summary of benefits available under your Priority Health plan. This summary is in addition to, not a substitution for, your Certificate of Coverage, Schedule of Copayments and Deductibles, and 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](http://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**

**Basic Benefits**

<b>Preventive Health Care Services</b>	
Preventive health care services are those services listed in Priority Health's Preventive Health Care Guidelines.	Services Covered in Full.
<b>Physician's Services</b>	
Primary Care Provider (PCP) Office Visit	\$15 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)	\$30 Copayment per visit.
Routine Pre and Post-natal Care	\$15 Copayment per visit to a maximum of four times the office visit Copayment per pregnancy.
Allergy Care	100% Coverage for injections and serum. Office visit Copayment may apply for testing.
<b>Outpatient Services</b> Diagnostic Laboratory and X-Ray Chemotherapy Radiation Therapy Hemodialysis	100% Coverage 100% Coverage 100% Coverage 100% Coverage
<b>Advanced Diagnostic Imaging</b> 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). 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 deductible and/or coinsurance.
<b>Rehabilitative Medicine Services</b>	
Physical and Occupational Therapy (includes Spinal Manipulation)	\$15 Copayment per visit for 30 visits per Contract Year (combined benefit for all therapies listed).
Speech Therapy	\$15 Copayment per visit for 30 visits per Contract Year
Cardiac Rehabilitation and Pulmonary Rehabilitation	\$15 Copayment per visit for 30 visits per Contract Year (combined benefit for all therapies listed).
<b>Note: If the above outpatient services are performed and processed in a physician's office, only the applicable office visit Copayment applies.</b>	

**SUMMARY OF BENEFITS HMO HOSPITAL PLAN**

<b>Hospital Services</b> (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.	100% Coverage
Inpatient Hospital Professional Services	100% Coverage
Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services)	100% Coverage Prior approval is required for certain radiology examinations.
Outpatient Hospital Professional Services	100% Coverage
<b>Certain Surgeries and Treatments (Physician fees only)</b> <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 seborrhic 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.  <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>
<b>Emergency Medical Care (in or out of the service area)</b>	
Hospital Emergency Room	\$100 Copayment per visit (waived if admitted)
Urgent Care Center	\$45 Copayment per visit
Physician's Office	Applicable office visit Copayment applies.
Ambulance (land or air)	\$100 Copayment
<b>Family Planning/Infertility Services</b>	
Vasectomy	100% Coverage when performed in a provider's office or 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 Counseling and Treatment of Underlying Cause of Infertility	50% Coverage. Prescription drugs for infertility treatment covered only with prescription drug rider.
<b>Mental Health/Substance Abuse Services</b> 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	100% Coverage. Maximum 20 days per Contract Year.
Outpatient Mental Health Services	\$20 Copayment. Maximum 20 visits per Contract Year. (\$10 Copayment per group therapy visit - two group therapy visits counts as one outpatient visit.)
Substance Abuse Services	80% Coverage up to the minimum annual benefit as determined by the State of Michigan per Contract Year.

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<b>Other Services</b>	
Dietitian Services	\$30 Copayment per visit. Up to six visits per Contract Year.
Durable Medical Equipment	50% Coverage
Prosthetics & Orthotics	50% Coverage
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	100% Coverage. Maximum 45 days per Contract Year (combined benefit for all services).
Home Health Care	Covered in full. For rehabilitative therapy provided in the home, refer to Rehabilitative Medicine services for Copayment information.
Temporomandibular Joint Syndrome (TMJS)	50% Coverage
Orthognathic Surgery	50% Coverage
Vision Care Exam Every 12 Consecutive Months	One eye exam (including refraction) with a participating provider every 12 consecutive months. \$15 Copayment. Limitations apply.
<b>Additional Benefits</b>	
<b>Pharmacy Services</b>	
Prescription Drugs	Covered with a \$10 Generic / \$40 Brand Copayment per prescription. Includes contraceptive medications and contraceptive devices. Infertility drugs covered with a 50% Copayment. (Limitations apply). No Rx Deductible.
Note: Prescription drug coverage is based on the usage of a medication formulary.	
Prescription Mail Order	Prescription drugs filled for up to 90 days with a \$20 Generic / \$80 Brand Copayment per prescription. No Rx Deductible. (Limitations apply.)
<b>Eligibility Information</b>	
Dependent Children	Covered until dependent turns age 26.