

Benefit Summary

PriorityHSA - PPO Premier

WOODLAND PARK ACADEMY

12/1/2010 - 11/30/2011

100% Network - 70%/30% Non-Network

The PPO plan offers you a choice of two benefit levels. The Network Benefits level applies when you use a Network provider. Your out-of-pocket costs are lower when you use this option. The Non-Network level applies when you seek medical services from a Non-Network provider.

The following information is provided as a summary of benefits available under your PPO plan. This summary is not intended as a substitute for your Policy and Schedule of Benefits. It is not a binding contract. Limitations and exclusions apply to benefits listed below. A complete listing of covered services, limitations and exclusions is contained in the Policy, Schedule of Benefits and any applicable Addenda issued to you. You may request a copy of the Policy from Priority Health's Customer Service Department at 616 464-8830 or 888 389-6645 or on our web site www.priorityhealth.com. Contact Priority Health's Customer Service Department if you have questions about your benefits or Coverage.

PRIOR APPROVAL

Prior approval is required before you may obtain certain services. If you seek services that require prior approval, without receiving prior approval from us, you will receive a reduction in benefit coverage for those services. You will also be responsible for those services that are beyond those approved, beyond the benefit maximums or excluded from Coverage.

You or your physician must call 800 269-1260 to obtain prior approval for services. Emergency admissions must be notified to us as soon as reasonably possible after admission.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS

A. Deductibles:

The Deductible is the amount of Covered Services you must incur during the Contract Year before benefits will be paid. The Network Benefits Deductible is applicable to all Covered Services except:

- Preventive health care services.
- Routine obstetrical services (deductible will apply to facility charges for delivery)

The Non-Network Benefit Deductible is applicable to all Covered Services received under the Non-Network Benefit level or received from Non-Network providers.

If you are the only individual on your contract, you have an Individual Contract and the Individual Contract Deductible below applies. If you have more than one individual on your contract, you have a Family Contract and only the Family Contract Deductible applies. The Family Contract Deductible can be satisfied by any one family member or by any combination of family members.

The Network and Non-Network Deductibles are calculated separately. You must meet the deductible at the Network Benefits level before benefits will be paid for services you seek under the Network Benefits. If you choose to use the Non-Network Benefits, you must meet the Deductible at the Non-Network Benefits level before benefits will be paid for services you seek under the Non-Network Benefits.

Deductible amounts you pay, whether under the Network Benefits or Non-Network Benefits, are included in any Network or Non-Network Out-of-Pocket Maximums.

Notwithstanding the above, the following costs do not apply towards the Deductibles: Services that exceed the annual day or dollar benefit maximum for a specific benefit (denied as non-Covered Services); and, penalties paid for failure to preauthorize services. The Deductible amounts renew each Contract Year. This plan does not carry over any Deductible amounts incurred in the prior Contract Year.

Your Network Benefits Deductible will take into account any monies paid under your prescription drug rider. See your prescription drug rider for more details.

Deductibles	Network Benefits	Non-Network Benefits
Individual Contract	\$1,200	\$3,000
Family Contract	\$2,400	\$6,000

B. Out-of-Pocket Maximums:

The Out-of-Pocket Maximum applies to certain services. The Out-of-Pocket maximum limits the total amount of covered expenses that you and/or your covered dependents will pay during a Contract Year, except as described below.

Out-of-Pocket Maximums	Network Benefits	Non-Network Benefits
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000

The out-of-pocket maximum limits the total amount of covered expenses that you or your covered dependents will pay during a plan year. Once the applicable out-of-pocket maximum for the network benefits level is met, all further medical covered services for that plan year for network benefits will be paid at 100% of Priority Health’s contracted rate. Once the applicable out-of-pocket for the non-network benefits level is met, all further medical covered services for that plan year for non-network benefits will be paid at 100% of the lesser of billed charges or reasonable and customary charges.

If you have individual coverage, you must meet the individual out-of-pocket maximum below. If you have more than one person on your contract, you have family coverage and only the family out-of-pocket applies. The family out-of-pocket can be satisfied by only one family member or by any combination of family members.

Notwithstanding the above, the following out-of-pocket costs do not apply towards the out-of-pocket maximum: Expenses for services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); penalties paid for failure to prior certify services; and costs paid by participants to provider for non-network benefits that exceed reasonable and customary.

Note: If the non-notification penalty applies, the amount Priority Health pays will be reduced even if the out-of-pocket maximum has been reached.

*Copayments and the 50% coinsurance tracks to the out of pocket maximums.

C. Maximum Individual Annual Benefit:

The combined maximum benefit per Member per Contract Year for all covered services at the Network and Non-Network Benefit levels is \$5,000,000.

LIFETIME MAXIMUM REQUIRED NOTICE

The combined (Network and Non-Network) lifetime limit on the dollar value of benefits no longer applies. Individuals whose coverage ended by reason of reaching a combined lifetime limit are eligible to enroll in this plan. Individuals may enroll during the group’s next open enrollment period or within 30 days after the group’s next renewal.

Covered Benefits

Benefits	Network Benefits	Non-Network Benefits
<p>Preventive Health Care Services A summary of Covered Preventive Health Care Services is contained in your Policy. Priority Health's complete preventive health care guidelines are available in our Member Center on our website priorityhealth.com, or you may request a copy from our Customer Service Department.</p>	<ul style="list-style-type: none"> • Services Covered in full • Deductible does not apply 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges • Deductible applies
PHYSICIAN SERVICES		
<p>Office and Home Visits (evaluation and management services only)</p>	<ul style="list-style-type: none"> • 100% Coverage • Deductible applies 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges • Deductible applies
<p>Inpatient Hospital Visits</p>	<ul style="list-style-type: none"> • 100% Coverage • Deductible applies 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges • Deductible applies
<p>Surgery</p>	<ul style="list-style-type: none"> • 100% Coverage • Deductible applies 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges • Deductible applies
<p>Ambulatory Surgery Center Services</p>	<ul style="list-style-type: none"> • 100% Coverage • Deductible applies 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges • Deductible applies
<p>Routine Pre and Post-natal Care</p>	<ul style="list-style-type: none"> • Services Covered in Full. • Deductible does not apply (deductible applies to facility and anesthesia charges for delivery) 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges • Deductible applies
<p>Vasectomy</p>	<ul style="list-style-type: none"> • 100% Coverage for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery • 100% Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery • Deductible applies 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery • 70% Coverage of Reasonable and Customary Charges for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
Tubal Ligation	<ul style="list-style-type: none"> • 100% Coverage for Physician services • 100% Coverage for outpatient facility charges • 100% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery • Deductible applies 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges for Physician services • 70% Coverage of Reasonable and Customary Charges for outpatient facility charges • 70% Coverage of Reasonable and Customary Charges for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery • Deductible applies
Consultations, pre-operative and post-operative visits (Evaluation and management services only)	<ul style="list-style-type: none"> • 100% Coverage • Deductible applies 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges • Deductible applies
Allergy Testing	<ul style="list-style-type: none"> • 100% Coverage • Deductible applies 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges • Deductible applies
Allergy Injections	<ul style="list-style-type: none"> • 100% Coverage • Deductible applies 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges • Deductible applies
Family Planning	<ul style="list-style-type: none"> • 50% Coverage • Deductible applies 	<ul style="list-style-type: none"> • 50% Coverage of Reasonable and Customary Charges • Deductible applies
Infertility Services (Covered for diagnosis and treatment of underlying cause only)	<ul style="list-style-type: none"> • 50% Coverage • Deductible applies 	<ul style="list-style-type: none"> • 50% Coverage of Reasonable and Customary Charges • Deductible applies
Temporomandibular Joint Dysfunction or Syndrome	<ul style="list-style-type: none"> • 50% Coverage • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies 	<ul style="list-style-type: none"> • 50% Coverage of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies
Orthognathic Surgery	<ul style="list-style-type: none"> • 50% Coverage • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies 	<ul style="list-style-type: none"> • 50% Coverage of Reasonable and Customary Charges • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
<p>Certain Surgeries and Treatments (Physician fees only) Bariatric surgery Reconstructive surgery: blepharoplasty of upper lids, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and surgical treatment of male gynecomastia. Skin Disorder Treatments: Scar revision, 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.</p>	<ul style="list-style-type: none"> • Physician fees are Covered at 50%, of the first \$2,000 for each certain surgery or treatment, 100% thereafter. • Prior approval required for bariatric surgery and all reconstructive surgeries. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Coverage is limited to one bariatric surgery per lifetime unless Medically/Clinically Necessary to correct or reverse complications from a previous bariatric procedure. • Deductible applies. 	<ul style="list-style-type: none"> • Physician fees are Covered at 50%, of the first \$2,000 of Reasonable and Customary Charges for each certain surgery or treatment, 100% thereafter. • Prior approval required for bariatric surgery and all reconstructive surgeries. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Coverage is limited to one bariatric surgery per lifetime unless Medically/Clinically Necessary to correct or reverse complications from a previous bariatric procedure. • Deductible applies.
HOSPITAL SERVICES (Including radiology examinations and laboratory services)		
<p>Inpatient Hospital and Long-Term Acute Care Services (Including observation care, transplants and maternity stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section)</p>	<ul style="list-style-type: none"> • 100% Coverage. • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Notification required for admissions following emergency room care. • Deductible applies. 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges. • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Notification required for admissions following emergency room care. • Deductible applies
<p>Outpatient Hospital Services (Including ambulatory surgery center facility charges)</p>	<ul style="list-style-type: none"> • 100% Coverage. • Some services may require prior approval. • Deductible applies. 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges. • Some services may require prior approval. • Deductible applies.

Benefits	Network Benefits	Non-Network Benefits
Medical Emergency and Urgent Care Services		
Emergency Room Services	<ul style="list-style-type: none"> • \$50 Copayment per visit. (Copayment waived only if you become confined in a Hospital.) Emergency Room physician, ancillary and special services are Covered at 100%. • Deductible applies. 	<ul style="list-style-type: none"> • \$50 Copayment per visit. (Copayment waived only if you become confined in a Hospital.) Emergency Room physician, ancillary and special services are Covered 70%. • Deductible applies.
Urgent Care Facility Services	<ul style="list-style-type: none"> • 100% Coverage. • Deductible applies. 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges. • Deductible applies. • Amounts paid after deductible do apply toward out-of-pocket maximums.
Ambulance Services	<ul style="list-style-type: none"> • \$50 Copayment. • Deductible applies. 	<ul style="list-style-type: none"> • \$50 Copayment. • Deductible applies.
Mental Health and Substance Abuse (Short-term therapy and crisis intervention) Prior approval by our Behavioral Health Department is required as noted. Call 616 464-8500 or 800 673-8043		
Mental Health Inpatient (including partial hospitalization)	<ul style="list-style-type: none"> • 100% Coverage up to 20 days per Contract Year* (Two partial hospitalization days count as one inpatient day) • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies. 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges up to 20 days per Contract Year* (Two partial hospitalization days count as one inpatient day) • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies.
Mental Health Outpatient	<ul style="list-style-type: none"> • 100% Coverage per visit up to 20 visits per Contract Year.* (Two group therapy visits count as one outpatient visit) • Deductible applies. 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges per visit up to 20 visits per Contract Year.* (Two group therapy visits count as one outpatient visit) • Deductible applies.
Substance Abuse Care Inpatient	<ul style="list-style-type: none"> • 100% Coverage up to the combined minimum annual benefit as determined by the State of Michigan per contract year.** • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies. 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges up to the combined minimum annual benefit as determined by the State of Michigan per contract year.** • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies.
Substance Abuse Care Outpatient	<ul style="list-style-type: none"> • 100% Coverage up to the combined minimum annual benefit as determined by the State of Michigan per contract year.** • Deductible applies. 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges up to the combined minimum annual benefit as determined by the State of Michigan per contract year.** • Deductible applies.

Benefits	Network Benefits	Non-Network Benefits
OTHER SERVICES		
Radiology Examinations and Laboratory Procedures	<ul style="list-style-type: none"> • 100% Coverage. • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies. 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges. • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies.
Prosthetic and Orthotics/Support Devices	<ul style="list-style-type: none"> • 50% Coverage. • Prior approval required for devices over \$1,000. • Deductible applies. 	<ul style="list-style-type: none"> • 50% Coverage of Reasonable and Customary Charges. • Prior approval required for devices over \$1,000. • Deductible applies.
Durable Medical Equipment (Rent, purchase or repair)	<ul style="list-style-type: none"> • 50% Coverage. • Prior approval required for devices over \$1,000. • Deductible applies. 	<ul style="list-style-type: none"> • 50% Coverage of Reasonable and Customary Charges. • Prior approval required for devices over \$1,000. • Deductible applies.
Facility Services (Non-hospital) <ul style="list-style-type: none"> • Skilled Nursing • Subacute • Inpatient Rehabilitation • Hospice 	<ul style="list-style-type: none"> • 100% Coverage up to the benefit maximum of 45 days per Contract Year.* • Prior approval required, except for Hospice. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies. 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges up to the benefit maximum of 45 days per Contract Year.* • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies.
Home Health Care	<ul style="list-style-type: none"> • 100% Coverage. • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies. 	<ul style="list-style-type: none"> • 70% Coverage of Reasonable and Customary Charges. • Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits. • Deductible applies.
Physical and Occupational Therapy (includes Spinal Manipulation) Combined benefit for all therapies listed.	<ul style="list-style-type: none"> • 100% Coverage up to 30 visits per contract year.* • Deductible applies. 	<ul style="list-style-type: none"> • 50% Coverage of Reasonable and Customary Charges up to the benefit maximum of 30 visits per Contract Year.* • Deductible applies.
Speech Therapy	<ul style="list-style-type: none"> • 100% Coverage up to 30 visits per contract year.* • Deductible applies 	<ul style="list-style-type: none"> • 50% Coverage of Reasonable and Customary Charges up to the benefit maximum of 30 visits per Contract Year.* • Deductible applies.
Cardiac Rehabilitation and Pulmonary Rehabilitation Combined benefit for all therapies listed.	<ul style="list-style-type: none"> • 100% Coverage up to 30 visits per contract year.* • Deductible applies 	<ul style="list-style-type: none"> • 50% Coverage of Reasonable and Customary Charges up to the benefit maximum of 30 visits per Contract Year.* • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
Additional Benefits		
Prescription Drugs Covered Prescription Drugs apply toward Network Benefit Deductibles and Out-of-Pocket Maximums.	<ul style="list-style-type: none"> 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). 	<ul style="list-style-type: none"> Not Covered.
Prescription Mail Order	<ul style="list-style-type: none"> Prescription drugs filled for up to 90 days with a \$20 Generic / \$80 Brand Copayment per prescription. (Limitations apply). 	<ul style="list-style-type: none"> Not Covered
Eligibility Information		
Dependent Children	Covered until dependent turns age 26.	Covered until dependent turns age 26.
<p><u>DEPENDENT COVERAGE REQUIRED NOTICE</u></p> <p><i>Individuals whose coverage ended or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26, are eligible to enroll in this plan. Individuals may enroll during the group's next open enrollment period or within 30 days after the group's next renewal.</i></p>		

MAXIMUM LIMITATIONS

- * **Benefit Maximums:** Benefit maximums up to a certain number of days/visits/dollar amounts per Contract Year are reached by combining either Network or Non-Network Benefits up to the limit for one or the other, but not both. (Example: If Network Benefits is for 60 visits and Non-Network Benefits is for 60 visits, the maximum benefit is 60 visits, not 120.) Benefit maximums apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum. The Family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person.
- ** **Substance Abuse:** Network and Non-Network inpatient and outpatient Coverage is provided up to a combined minimum annual benefit as determined by the State of Michigan per Contract Year. Coverage amount to be adjusted each March 31st in accordance with the average percentage increase in the "Consumer Price Index for All Urban Consumer-Revised" (CCPI). Coverage amount may be adjusted by an attached Addendum.

GRANDFATHERED PLAN REQUIRED NOTICE

We believe this plan is a grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. Contact our Customer Service Department at: Customer Service Department MS 1105, PO Box 269, Grand Rapids, MI 49501-0269 or 1231 E. Beltline NE, Grand Rapids, MI 49525-4501, phone 616 464-8830 or 888 389-6645 or use our secure e-mail form in the member center on our website www.priorityhealth.com. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.