Schedule of Benefits
My**Priority** PPO℠

80% Network — 60% Non-Network

Your Policy provides you with important information about your health care benefits, including prior approval requirements and your Coverage level choices. You may obtain medical services from a Network Provider and receive a higher level of benefits (the Network Benefits level), or you may obtain services from a Non-Network Provider and have coverage under the Non-Network Benefits level.

This Schedule of Benefits provides you with information about your costs at both benefit levels when you receive health care services and the maximum limitations of your health care benefits. Read the entire Policy, Schedule of Benefits and any Plan Addenda carefully.

In accordance with the terms and conditions of the Policy, you are entitled to Covered Services when these services are:

A. Medically/Clinically Necessary (as defined in the Policy and according to Medical and Behavioral Health policies established by Priority Health with the input of physicians not employed by Priority Health or according to criteria developed by reputable external sources and adopted by Priority Health); and

B. Not excluded in the Policy or in an Addendum or an Amendment to the Policy.

PRE-EXISTING CONDITION EXCLUSION

Benefits will be excluded for each Illness or Injury or condition not disclosed on your application, for which, during the six month period prior to your effective date, medical advice, diagnosis, care or treatment was recommended by or received from a Health Professional. For purposes of this limitation, "treatment" includes the use of prescription drugs. Genetic information is not treated as a Pre-Existing Condition in the absence of a diagnosis of a condition related to the genetic information.

This Pre-Existing Condition exclusion will apply until the end of the twelve-month period beginning on your effective date under this Policy. The Pre-Existing Condition exclusion does not apply to a newborn who becomes a Covered Dependent under this Policy within 31 days after the birth.

BENEFIT WAITING PERIOD

Certain surgeries and the treatment of certain conditions are excluded from Coverage during your first six (6) months of Coverage under the Policy, beginning with your most recent effective date. Surgeries subject to the six month waiting period include: Tonsillectomy, Adenoidectomy, Hemorrhoidectomy, Hysterectomy and Bunionectomy, Surgical treatment of the following conditions are also subject to the six month waiting period: Cystocele, Enterocele, Rectocele, Urethrocele, Uterine Prolapse, Inguinal Hernia (other than strangulated or incarcerated), Carpal Tunnel Syndrome and Varicose Veins.

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, your benefits will be reduced 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 reported to us as soon as reasonably possible after admission.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS

A. Deductibles:

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

- First four office visits per Member per Contract Year,
- Prescription drugs benefits, and

- Preventive health services (except colorectal exams and human papilloma virus immunizations) designated to maintain an individual in optimum health and to prevent unnecessary injury, illness or disability. Prenatal and pregnancy services are not Covered under the Policy.

The Non-Network Benefit Deductible is applicable to all Covered Services, except prescription drug benefits.

Notwithstanding the above, the following out-of-pocket Member costs do not apply towards the Deductibles:

- any monies you paid for Non-Covered Services; and
- any monies you paid for Covered Services that exceed the annual day, visit or dollar benefit maximum for a specific benefit and therefore, denied as non-Covered Services; and
- any reduction in payment for failure to preauthorize services; and
- any monies you paid to providers for Non-Network Benefits that exceed Reasonable and Customary; and
- any monies you paid for Covered Services after the Lifetime Benefit Maximum is exhausted.

The Network and Non-Network Deductibles are calculated separately. Deductible amounts you pay, whether under the Network Benefits or Non-Network Benefits, are excluded from any Network or Non-Network Out-of-Pocket Maximums.

The Deductible renews each Contract Year. Deductible amounts do not carry over into a new Contract Year.

Deductibles	Network Benefits	Non-Network Benefits
Subscriber Only Contract	$3,500.00	$ 7,000.00
Subscriber Plus Dependent(s) Contract	$7,000.00 (but not to exceed the Subscriber Only Deductible per person)	$14,000.00 (but not to exceed the Subscriber Only Deductible per person)

B. Out-of-Pocket Maximums:

The Out-of-Pocket Maximum applies to certain Network Benefits level services. The Network Benefits Out-of-Pocket maximum limits the total amount of Covered Network Benefits expenses that you or your Covered Dependents will pay during a Contract Year, except as described below.

Out-of-Pocket Maximums	Network Benefits	Non-Network Benefits
Subscriber Only Contract	$2,000.00	Not Applicable
Subscriber Plus Dependent(s) Contract	$4,000.00 (but not to exceed the Subscriber Only Out-of-Pocket Maximum per person)	Not Applicable

Amounts paid for any of the following will not apply toward the Out-of-Pocket Maximum:

- any flat dollar Copayments, such as Copayments for office visits, emergency room and urgent care visits
- any monies you paid for prescription drugs – retail pharmacy
- any reduction in benefits for failure to obtain prior approval when necessary
- Deductibles
- any monies you paid for non-Covered Services
- any monies you paid for Covered Services that exceed the annual day/visit or dollar benefit maximum for a specific benefit and therefore, denied as non-Covered Services
- any monies you paid to providers for Non-Network Benefits
- any monies you paid to providers for Non-Network Benefits that exceed Reasonable and Customary
- any monies you paid for Covered Services after the Lifetime Benefit Maximum is exhausted

After meeting the Out-of-Pocket Maximum, the Copayments for Network Benefits services still apply.

Note: Copayments made for any Network Benefits Covered Services obtained under a supplemental benefit Addendum may not be applied toward the above Network Benefits Out-of-Pocket Maximum. If your plan has a Deductible, the Deductible amounts you pay will not apply toward the Network Benefits Out-of-Pocket Maximum.

Note: If the Network Benefits Subscriber Only Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Covered Network Benefits Services that apply toward Network Benefits Out-of-Pocket Maximums as incurred by that person for the rest of the Contract Year. If the Network Benefits Subscriber Plus Dependent(s) Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Reasonable and Customary Charges for Covered Network Benefits Services incurred by you and all your Covered Dependents for the rest of the Contract Year.

Note: If the reduction in benefits for failure to obtain prior approval applies, the amount Priority Health pays will be reduced even if the Network Benefits Out-of-Pocket Maximum has been reached.

C. Maximum Lifetime Benefit Per Member:

$5,000,000.00 is the combined lifetime maximum benefit per Member for all Network and Non-Network Covered Services*.

$1,000,000.00 is the combined lifetime maximum transplant benefit per Member for all Covered transplants. This amount is included in and part of the Maximum Lifetime Benefit per Member described above.

Covered Benefits

Benefits	Network Benefits	Non-Network Benefits
Preventive Health Services Per our Preventive Health Care Guidelines Prenatal and pregnancy services are not Covered under the Policy. **Note:** Coverage for Preventive Health Care Services is subject to a 90-day waiting period.	After a 90-day waiting period which begins on your effective date: • 100% Coverage for Preventive Health Care Services described in our Preventive Health Care Guidelines (except as stated below) up to a maximum benefit of $500.00 per Member per Contract Year. Deductible does not apply. • 80% Coverage for colorectal exams (colonoscopy/sigmoidoscopy) and human papillomavirus (HPV) immunizations. Deductible applies. • 80% Coverage for further Preventive Care Services during the same Contract Year. Deductible applies.	**Not Covered**
PHYSICIAN SERVICES		
Office Visits and Urgent Care Visits Visits for Sickness, Injury, or follow-up (face-to-face, telephonic, or through secure electronic portal)	• $30.00 Copayment per visit for the first four visits per Member per Contract Year. Deductible applies. • 80% Coverage for office and urgent care visits for the remainder of the Contract Year. Deductible does not apply. Prescription drug Copayment may also apply when selected injectable drugs are provided	• 60% Coverage of Reasonable and Customary Charges for face-to-face visits only • Deductible applies • Prescription drug Copayment may also apply when selected injectable drugs are provided
Inpatient Hospital Visits	• 80% Coverage • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges • Deductible applies
Surgery	• 80% Coverage • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges • Deductible applies
Ambulatory Surgery Center Services	• 80% Coverage for physician surgical charges • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
Allergy Testing and Serum	• 80% Coverage • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges • Deductible applies
Allergy Injections	• 80% Coverage • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges • Deductible applies
Maternity Services (Prenatal delivery and postnatal) **Note:** Complications of a Pregnancy, as defined in Section 16 of the Policy, are Covered subject to the terms and conditions of the Policy.	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Family Planning	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Infertility Services	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Tubal Ligation	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Vasectomy	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Temporomandibular Joint Dysfunction or Syndrome	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Orthognathic Surgery	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)

Benefits	Network Benefits	Non-Network Benefits
Certain Surgeries and Treatments • Reconstructive surgeries o Blepharoplasty o Breast reduction o Panniculectomy o Rhinoplasty o Septorhinoplasty o Surgical treatment of male gynecomastia • Skin disorder treatments o Scar revision o Keloid scar treatment o Treatment of hyperhidrosis o Excision of lipomas o Excision of seborrheic keratoses o Excision of skin tags o Treatment of vitiligo o Port wine stain and hemangioma treatment • Sleep apnea treatment procedures	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Treatment of Morbid Obesity • Weight loss programs • Bariatric surgery	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Transplants	• 80% Coverage to a $1,000,000.00 Combined Maximum Lifetime Transplant Benefit per Member. This amount is included in and part of the Maximum Lifetime Benefit under this Policy. • Deductible applies • Amounts paid after the Deductible apply toward Out-of-Pocket Maximums .	**Not Covered** (including Physicians' fees and any other related charges)

Benefits	Network Benefits	Non-Network Benefits
HOSPITAL SERVICES (Including radiology examinations and laboratory services)		
Inpatient Hospital and Inpatient Longterm Acute Care Services (Including observation care, transplants and maternity stays for a mother and her Newborn of up to 96 hours following a Medically/Clinically Necessary cesarean section) Prenatal and pregnancy services are not Covered under this Policy.	• 80% Coverage • Prior approval required at least five working days in advance, except in emergencies or for hospital stays for a mother and her Newborn of up to 96 hours following a Medically/Clinically Necessary cesarean section. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Notification required for admissions following emergency room care • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges • Prior approval required at least five working days in advance, except in emergencies or for hospital stays for a mother and her Newborn of up to 96 hours following a cesarean section. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Notification required for admissions following emergency room care • Deductible applies •
Outpatient Hospital Services (Including ambulatory surgery center facility charges)	• 80% Coverage • Some services may require prior approval, including certain radiology examinations • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges • Some services may require prior approval, including certain radiology examinations • Deductible applies
MEDICAL EMERGENCY SERVICES		
Emergency Room Services (Non-emergency use of the emergency room is not Covered)	• $150.00 Copayment (waived if admitted to the hospital as an inpatient within 24 hours), then subject to: • 80% Coverage • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• $150.00 Copayment (waived if admitted to the hospital as an inpatient within 24 hours), then subject to: • 60% Coverage of Reasonable and Customary Charges • Deductible applies
Urgent Care Facility Services	See **Office Visits and Urgent Care Visits** category under PHYSICIAN SERVICES section of this Schedule of Benefits	See **Office Visits and Urgent Care Visits** category under PHYSICIAN SERVICES section of this Schedule of Benefits
Ambulance Services (air or ground)	• 80% Coverage • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
BEHAVIORAL HEALTH SERVICES		
Mental Health Inpatient (including partial hospitalization)	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Mental Health Outpatient	**Not Covered** (including Physicians' fees and any other related charges)	**Not Covered** (including Physicians' fees and any other related charges)
Substance Abuse Care (Inpatient and Outpatient)	• 80% Coverage up to the combined maximum benefit per Member per Contract Year.* 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). • Prior approval required for Inpatient services. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 60% Coverage of Reasonable and Customary Charges up to the combined maximum benefit per Member per Contract Year.* 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). • Prior approval required for Inpatient services. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
REHABILITATIVE MEDICINE SERVICES		
Rehabilitative Medicine Services Outpatient Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation, Osteopathic Manipulations and Chiropractic Spinal Manipulations	• 80% Coverage up to the combined maximum benefit of $3,000.00 per Member per Contract Year* • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges up to the combined maximum benefit of $3,000.00 per Member per Contract Year.* • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
OTHER SERVICES		
Radiology Examinations and Laboratory Procedures	• 80% Coverage • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Durable Medical Equipment (rent, purchase or repair)**; and Prosthetic and Orthotic/Support Devices**	• 50% Coverage up to a combined benefit maximum of $2,000.00 per Member per Contract Year* • Prior approval required for devices over $1,000.00 • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums •	• 50% Coverage of Reasonable and Customary Charges up to a combined benefit maximum of $2,000,00 per Member per Contract Year* • Prior approval required for devices over $1,000.00 • Deductible applies
Non-Acute Hospital Facility Services • Skilled Nursing Facility • Subacute Facility • Inpatient Rehabilitation Facility • Hospice Facility	• 80% Coverage up to the benefit maximum of 60 days per Contract Year* • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges up to the benefit maximum of 60 days per Contract Year* • Prior approval required. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Home Health Care (Including hospice care in the home, excluding Rehabilitative Medicine) **Note:** Rehabilitative services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described above.	• 80% Coverage up to the benefit maximum of 60 days per Contract Year* • Prior approval required except for hospice services in the home. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies • Amounts paid after Deductible apply toward Out-of-Pocket Maximums	• 60% Coverage of Reasonable and Customary Charges up to the benefit maximum of 60 days per Contract Year* • Prior approval required except for hospice services in the home. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies
Dietician Services	• 80% Coverage to a maximum benefit of 6 visits per Member per Contract Year* • Deductible applies • Amounts paid after Deductible do apply toward Out-of-Pocket Maximums	**Not Covered**

MEDICAL PLAN PHARMACY SERVICES

In general, Covered drugs are treated as medical benefits when administered in an inpatient or emergency setting, or when the drug requires injection or infusion by a Health Professional. Exceptions to this rule are outlined in our medical policies.

The Deductible will apply to Covered medical plan pharmacy services that are detailed below.

Medication Formulary - A list of both Generic and Brand Name Drugs, including Specialty Drugs, approved by Priority Health Pharmacy and Therapeutics Committee for use by our Members. Preferred Brand Name Drugs are usually Brand Name Drugs that have been on the market for a while or are commonly prescribed and have been selected based on their clinical effectiveness and safety. Non-preferred Brand Name Drugs are usually the highest cost drugs in a given category that have lower-cost alternatives with equal or better clinical effectiveness.

Specialty Drug - Drugs listed on the Medication Formulary meeting certain criteria, such as:

- drugs or drug classes whose cost on a per- month or per-dose basis exceeds the threshold established by the Centers for Medicare and Medicaid Services; or
- drugs that require special handling or administration; or
- drugs that have limited distribution; or
- drugs in selected therapeutic categories.

Specialty Pharmacy - A Pharmacy that specializes in the handling, distribution, and patient management of Specialty Drugs.

Benefits	Network Benefits	Non-Network Benefits
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)	• 80% Coverage to a combined maximum benefit of $25,000.00 per Member per Contract Year* • Deductible applies • Amounts paid after Deductible do apply toward Out-of-Pocket Maximums • Prior approval required. Step therapy may be required before drugs will be Covered. • Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy.	• 60% Coverage to a combined maximum benefit of $25,000.00 per Member per Contract Year* • Deductible applies • Amounts paid after Deductible do apply toward Out-of-Pocket Maximums • Prior approval required. Step therapy may be required before drugs will be Covered. • Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy.

PRESCRIPTION DRUG BENEFITS - RETAIL PHARMACY		
Benefits	**Network Benefits**	**Non-Network Benefits**
Retail Pharmacy Services (prescription drugs obtained at a retail Network Pharmacy dispensed in a 31-day supply per prescription or refill or through our mail order service dispensed in a 90-day supply per prescription or refill) In general, Covered retail pharmacy drugs are treated as outpatient prescription drug benefits when they can be self-administered regardless of the setting. Exceptions to this rule are outlined in our medical policies. **Note:** If you elect to receive a Brand Name Drug when the prescription allows a Generic Drug substitution, you may be responsible for difference in cost between the Generic Drug and the Brand Name Drug. Prior approval or step therapy may be required.	• 60% Coverage for a Generic or Brand Name Drug on our Medication Formulary to a maximum benefit of $5,000.00 per Member per Contract Year. Limitations and exclusions apply. • Self-administered injectable drugs must be obtained at a Network Pharmacy (including Participating Specialty Pharmacies for selected drug categories) • Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy	**Not Covered.** **Exception**: Prescription drugs dispensed by a Non-Network Pharmacy during a Medical Emergency or Urgent Care situation will be Covered under the Retail Pharmacy Services Network Benefits level.

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.

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