EPO Benefits are provided or coordinated by your primary care provider ("PCP") or provided by a participating provider for office services. Services may require prior certification with the Benefit Administrator (except in a medical emergency). For a current status of Priority Health participating providers, call the Customer Service Department at 616 956-1954 or 800 956-1954. A listing of Priority Health participating providers is also available on the Internet at priorityhealth.com.

Prior Certification: Prior certification is required for all inpatient hospital or facility services. Non-emergency admissions must be prior certified at least five working days before admission. Emergency admissions must notify the Benefit Administrator as soon as reasonably possible after admission. You or your PCP must call 800 269-1260 to prior certify services. You do not need prior approval from Priority Health for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Other services requiring prior certification are:

- Home Health Care
- Skilled Nursing, Sub acute & Long-term Acute Facility Care
- Inpatient Rehabilitation Care
- Durable Medical Equipment over $1,000
- Clinical Trials (all stages) for Cancer or a Life-threatening Illness/Condition
- Hospice Care
- Transplants
- Imaging Services
- Prosthetic Devices over $1,000

The full list of services that require prior certification is included in the SPD and may be updated from time to time. A current listing is also available by calling the Priority Health Customer Service Department at 616 956-1954 or 800 956-1954. Other services may be prior certified by you or your provider to determine medical/clinical necessity before treatment. Prior certification is not a guarantee of coverage or a final determination of benefits under this plan.

If you are receiving intensive treatment for mental health services, including inpatient hospitalization and partial hospitalization, you or your PCP must notify our Behavioral Health Department as soon as possible for assistance. Call our Behavioral Health department at 616 464-8500 or 800 673-8043 for assistance.

The following information is provided as a summary of benefits available under your plan. This summary is not intended as a substitute for your Summary Plan Description. 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 Summary Plan Description and any applicable amendments to the plan.

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>CHOICE BENEFITS</th>
<th>STANDARD BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$350 per individual; and $700 per family per plan year.</td>
<td>$500 per individual; and $1,000 per family per plan year.</td>
</tr>
<tr>
<td>Benefit Percentage Rate</td>
<td>90% paid by the plan; 10% paid by the participant, unless otherwise noted.</td>
<td>75% paid by the plan; 25% paid by the participant, unless otherwise noted.</td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td>$1,800 per individual/$3,600 per family per plan year.</td>
<td>$2,800 per individual/$5,600 per family per plan year.</td>
</tr>
<tr>
<td>Maximum Individual Plan Year Benefit</td>
<td>Not applicable.</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Reduction of Benefits Penalty</td>
<td>Not applicable.</td>
<td>Not applicable.</td>
</tr>
</tbody>
</table>
### Preventive Health Care Services

Preventive Health Care Services are described in Priority Health’s Preventive Health Care Guidelines available in the member center on our web site at [priorityhealth.com](http://priorityhealth.com) or you may request a copy from our Customer Service Department. Priority Health’s Guidelines include preventive services required by legislation.

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>CHOICE BENEFITS</th>
<th>STANDARD BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Physical Exams &amp; Services</strong></td>
<td>Covered in full. deductible does not apply.</td>
<td>Covered in full. deductible does not apply.</td>
</tr>
<tr>
<td><strong>Women’s Preventive Health Services</strong></td>
<td>Covered in full. deductible does not apply.</td>
<td>Covered in full. deductible does not apply.</td>
</tr>
<tr>
<td><strong>Routine Pap Smears</strong></td>
<td>Covered in full. deductible does not apply.</td>
<td>Covered in full. deductible does not apply.</td>
</tr>
<tr>
<td><strong>Routine Mammograms</strong></td>
<td>Covered in full. deductible does not apply.</td>
<td>Covered in full. deductible does not apply.</td>
</tr>
<tr>
<td><strong>Prostate or Rectal/Colon Cancer Screening Test</strong></td>
<td>Covered in full. deductible does not apply.</td>
<td>Covered in full. deductible does not apply.</td>
</tr>
<tr>
<td><strong>Well Child Care</strong></td>
<td>Covered in full. deductible does not apply.</td>
<td>Covered in full. deductible does not apply.</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>Covered in full. deductible does not apply.</td>
<td>Covered in full. deductible does not apply.</td>
</tr>
</tbody>
</table>

### Medical Office Services

<p>| <strong>Primary Care Physician (PCP) Office Visits</strong>     | $25 copayment per visit (face-to-face, telephonic, or through secure electronic portal). deductible does not apply. | $35 copayment per visit (face-to-face, telephonic, or through secure electronic portal). deductible does not apply. |
| <strong>Specialists Office Visits</strong>                      | $35 copayment per visit (face-to-face, telephonic, or through secure electronic portal). deductible does not apply. | $45 copayment per visit (face-to-face, telephonic, or through secure electronic portal). deductible does not apply. |
| <strong>Office Surgery</strong>                                 | Covered at 90% after deductible.                                             | Covered at 75% after deductible.                                                 |
| <strong>Office Injections</strong>                              | Covered at 90% after deductible.                                             | Covered at 75% after deductible.                                                 |
| <strong>Allergy Services</strong>                               | Covered 100%. deductible does not apply.                                     | Covered 100%. deductible does not apply.                                         |
| <strong>Allergy Testing</strong>                                | Covered at 50% after deductible.                                             | Covered at 50% after deductible.                                                 |
| <strong>Diagnostic Radiology and Lab Services</strong>          | Covered at 90% after deductible.                                             | Covered at 75% after deductible.                                                 |
| <strong>Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies</strong> | $150 copayment per occurrence. deductible applies. Annual maximum of 10 copayments per individual. | $150 copayment per occurrence. deductible applies. Annual maximum of 10 copayments per individual. |
| <strong>Routine Obstetrical Services by Physician</strong>      | Routine prenatal and postnatal visits are covered at 100%, deductible waived under the Preventive Health Care Services benefits above. See the Hospital Services section for facility and physician benefits related to obstetrical services, including delivery and nursery services. | Routine prenatal and postnatal visits are covered at 100%, deductible waived under the Preventive Health Care Services benefits above. See the Hospital Services section for facility and physician benefits related to obstetrical services, including delivery and nursery services. |
| <strong>Prenatal Classes</strong>                               | $25 copayment per visit. deductible does not apply.                         | $35 copayment per visit. deductible does not apply.                             |
| <strong>Dietitian Services</strong>                             | $25 copayment per visit up to a maximum of six visits per plan year. deductible does not apply. | $35 copayment per visit up to a maximum of six visits per plan year. deductible does not apply. |
| <strong>Education Services</strong>                             | $25 copayment per visit. deductible does not apply.                         | $35 copayment per visit. deductible does not apply.                             |</p>
<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>CHOICE BENEFITS</th>
<th>STANDARD BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Services</strong></td>
<td><strong>Inpatient Hospital and Inpatient Long-term Acute Care Services</strong>&lt;br&gt;Prior approval is required except in emergencies or for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Prior certification phone number is 800 269-1260.</td>
<td>Covered at 90% after deductible.</td>
</tr>
<tr>
<td><strong>Inpatient Professional Charges</strong></td>
<td>Covered at 90% after deductible.</td>
<td>Covered at 75% after deductible.</td>
</tr>
<tr>
<td><strong>Human Organ Tissue Transplants</strong></td>
<td>Covered at 90% after deductible.</td>
<td>Covered at 75% after deductible.</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Facility Services</strong></td>
<td>Covered at 90% after deductible.</td>
<td>Covered at 75% after deductible.</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Professional Charges</strong></td>
<td>Covered at 90% after deductible.</td>
<td>Covered at 75% after deductible.</td>
</tr>
<tr>
<td><strong>Approved Clinical Trial Expenses</strong></td>
<td>Covered at 90% after deductible.</td>
<td>Covered at 75% after deductible.</td>
</tr>
<tr>
<td><strong>Hospital Diagnostic Laboratory &amp; Radiology Services</strong></td>
<td>Covered at 90% after deductible.</td>
<td>Covered at 75% after deductible.</td>
</tr>
<tr>
<td><strong>Hospital Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies</strong>&lt;br&gt;Prior certification required.</td>
<td>$150 copayment per occurrence. Deductible applies. $150 copayment per occurrence. Deductible applies.</td>
<td>Annual maximum of 10 copayments per individual. Annual maximum of 10 copayments per individual.</td>
</tr>
<tr>
<td><strong>Certain Surgeries and Treatments</strong></td>
<td>Physician fees are covered at 50% after deductible of the first $2,000 for each certain surgery or treatment, 100% thereafter. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty.</td>
<td>Physician fees are covered at 50% after deductible of the first $2,000 for each certain surgery or treatment, 100% thereafter. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty.</td>
</tr>
<tr>
<td><strong>Bariatric Surgery</strong> (limited to one per lifetime)**</td>
<td></td>
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</tr>
<tr>
<td><strong>Reconstructive surgery</strong>: blepharoplasty of upper eyelids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty* and surgical treatment of male gynecomastia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skin Disorder Treatments</strong>: 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Varicose veins treatments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sleep apnea treatment procedures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Emergency and Urgent Care Services</strong></td>
<td><strong>Emergency Room Services</strong>&lt;br&gt;$100 copayment per visit. Deductible does not apply. <em>(Copayment waived if admitted.)</em></td>
<td>$100 copayment per visit. Deductible does not apply. <em>(Copayment waived if admitted.)</em></td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>$50 copayment. Deductible applies.</td>
<td>$50 copayment. Deductible applies.</td>
</tr>
<tr>
<td><strong>Urgent Care Facility Services</strong></td>
<td>$55 copayment per visit. Deductible does not apply.</td>
<td>$65 copayment per visit. Deductible does not apply.</td>
</tr>
<tr>
<td>BENEFITS</td>
<td>CHOICE BENEFITS</td>
<td>STANDARD BENEFITS</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Behavioral Health Services - Prior certification by our Behavioral Health Department is required, except in emergencies, for inpatient services as noted below: Call 616 464-8500 or 800 673-8043.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Mental Health &amp; Substance Abuse Services (including rehabilitation and partial hospitalization) Prior certification required except in emergencies.</td>
<td>Covered at 90% after deductible.</td>
<td>Covered at 75% after deductible.</td>
</tr>
<tr>
<td>Outpatient Mental Health &amp; Substance Abuse Services (including medication management visits)</td>
<td>$25 copayment per visit. Deductible does not apply.</td>
<td>$35 copayment per visit. Deductible does not apply.</td>
</tr>
<tr>
<td>Family Planning and Reproductive Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Counseling &amp; Treatment Covered for diagnosis and treatment of underlying cause only. Limitations and exclusions apply.</td>
<td>Covered at 50% after deductible.</td>
<td>Covered at 50% after deductible.</td>
</tr>
</tbody>
</table>
| Vasectomy Covered only when performed in physician’s office or when in connection with other covered inpatient or outpatient surgery. | Covered 100%, deductible waived when performed in a provider’s office.  
Covered at 90% after deductible when performed in all other locations. | Covered 100%, deductible waived when performed in a provider’s office.  
Covered at 75% after deductible when performed in all other locations. |
| Tubal Ligation/Tubal Obstructive Procedures (included as part of the Women’s Preventive Health Services benefits.) | Covered at 100%, deductible waived when performed at outpatient facilities.  
If received during an inpatient stay, only the services related to the tubal ligation/tubal obstructive procedure are covered at 100%, deductible waived. | Covered at 100%, deductible waived when performed at outpatient facilities.  
If received during an inpatient stay, only the services related to the tubal ligation/tubal obstructive procedure are covered at 100%, deductible waived. |
| Birth Control Services Medical Plan (i.e. doctor’s office) (included as part of the Women’s Preventive Health Services benefits.) Includes; diaphragms, implantables, injectables, and IUD (insertion and removal), etc. | Covered at 100%, deductible waived. | Covered at 100%, deductible waived. |
| Rehabilitative Medicine Services                                         |                                     |                                    |
| Physical and Occupational Therapy $35 copayment up to a combined benefit maximum of 30 visits per plan year. Deductible does not apply. | $45 copayment up to a combined benefit maximum of 30 visits per plan year. Deductible does not apply. |
| Speech Therapy $35 copayment up to a benefit maximum of 30 visits per plan year. Deductible does not apply. | $45 copayment up to a benefit maximum of 30 visits per plan year. Deductible does not apply. |
| Cardiac Rehabilitation and Pulmonary Rehabilitation $35 copayment up to a combined benefit maximum of 30 visits per plan year. Deductible does not apply. | $45 copayment up to a combined benefit maximum of 30 visits per plan year. Deductible does not apply. |
| Chiropractic Services $35 copayment up to a benefit maximum of 25 visits per plan year. Deductible does not apply. | $45 copayment up to a benefit maximum of 25 visits per plan year. 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.
<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>CHOICE BENEFITS</th>
<th>STANDARD BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Services</td>
<td>Retail Pharmacy:</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Prescription Drugs – Medication Formulary</td>
<td>Generic Drugs: $10 copayment</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Includes disposable needles and syringes for diabetics.</td>
<td>Preferred Brand Name Drugs: $40 copayment</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Infertility drugs covered with a 50% copayment. (Limitations apply)</td>
<td>Non-Preferred Brand Name Drugs**: $80 copayment</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Any medications provided in the Priority Health’s Preventive Health Care Guidelines, including certain women’s prescribed contraceptive methods are covered at 100%, copayments waived.</td>
<td>Preferred Specialty Drugs**: $40 copayment</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Brand-name oral and injectable contraceptives are subject to applicable prescription drug copayments. (Limitations apply.)</td>
<td>Non-Preferred Specialty Drugs**: $80 copayment</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>**Subject to prior authorization and/or step therapy.</td>
<td>Mail Service Program (up to 90 days):</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Generic Drugs: $20 copayment</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Prior certification is required for charges over $1,000. Limitations apply.</td>
<td>Preferred Brand Name Drugs: $80 copayment</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Prosthetic &amp; Orthotic/Support Devices</td>
<td>Non-Preferred Brand Name Drugs**: $160 copayment</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Prior certification is required for charges over $1,000. Limitations apply.</td>
<td>Preferred Specialty Drugs**: $40 copayment Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Temporomandibular Joint Syndrome (TMJS) Treatment</td>
<td>Non-Preferred Specialty Drugs**: $80 copayment Specialty Drugs are limited to a maximum of a 31-day supply per prescription or refill.</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Limitations apply.</td>
<td>**Subject to prior authorization and/or step therapy.</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Orthognathic Treatment</td>
<td>Covered at 50% after deductible.</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Limitations apply.</td>
<td>Covered at 50% after deductible.</td>
<td>Covered at 50% after deductible.</td>
</tr>
<tr>
<td>Skilled Nursing, Inpatient Rehabilitation and Hospice Facilities</td>
<td>Covered at 90% after deductible up to a maximum benefit of 45 days per plan year combined for all services.</td>
<td>Covered at 75% after deductible up to a maximum benefit of 45 days per plan year combined for all services.</td>
</tr>
<tr>
<td>Covered at 50% after deductible.</td>
<td>Covered at 100% after deductible.</td>
<td>Covered at 100% after deductible.</td>
</tr>
<tr>
<td>Home Health Services (including hospice services, excluding rehabilitative medicine)</td>
<td>Covered at 90% after deductible.</td>
<td>Covered at 75% after deductible.</td>
</tr>
<tr>
<td>Limitations apply.</td>
<td>Covered at 100% after deductible.</td>
<td>Covered at 75% after deductible.</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>Custodial Care/Private Duty Nursing/Home Health Aides</td>
<td>Covered at 90% after deductible.</td>
</tr>
<tr>
<td>Covered at 90% after deductible.</td>
<td>Covered at 75% after deductible.</td>
<td>Covered at 75% after deductible.</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>Vision Care Exam (includes refraction)</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Covered at 90% after deductible.</td>
<td>$25 copayment per visit. Deductible does not apply. Limited to one exam per plan year.</td>
<td>$25 copayment per visit. Deductible does not apply. Limited to one exam per plan year.</td>
</tr>
<tr>
<td>Coverage Information</td>
<td>Waiting Period Requirement</td>
<td>See the SPD for eligibility requirements.</td>
</tr>
<tr>
<td>Full-Time Employee</td>
<td>See the SPD for eligibility requirements.</td>
<td></td>
</tr>
<tr>
<td>Part-Time Employee</td>
<td>See the SPD for eligibility requirements.</td>
<td></td>
</tr>
<tr>
<td>Early Retiree Coverage</td>
<td>Available.</td>
<td></td>
</tr>
<tr>
<td>Dependent Children</td>
<td>Covered to the end of the day in which they turn age 26. Over age 26 if mentally or physically incapacitated dependent.</td>
<td></td>
</tr>
<tr>
<td>Pre-Existing Condition Limitation</td>
<td>Not applicable.</td>
<td></td>
</tr>
<tr>
<td>Motor Vehicle Injuries</td>
<td>Coordinated with motor vehicle insurance.</td>
<td></td>
</tr>
<tr>
<td>Motorcycle Injuries</td>
<td>Coordinated with motor vehicle insurance.</td>
<td></td>
</tr>
</tbody>
</table>
### PHCS Travel Network Benefit

<table>
<thead>
<tr>
<th><strong>Submit Claims for PHCS/ Multiplan Travel Network to:</strong></th>
<th><strong>When emergent/urgent care is needed or when medical care is prior authorized for treatment outside the Priority Health service area, benefits will be paid at the Priority Health Network benefit level when you use a PHCS or Multiplan Provider. For a current provider listing, please contact PHCS/Multiplan at the following:</strong></th>
</tr>
</thead>
</table>
| **Priority Health Managed Benefits, Inc.**<br>P.O. Box 232<br>Grand Rapids, MI 49501-0232 | **Phone Line:** 888 785-7427  
**Internet Web Site:** multiplan.com |

In accordance with the terms and conditions of the SPD, you are entitled to covered services when these services are:

A. Medically/clinically necessary; and  
B. Not excluded in the SPD.

**You will be responsible for services rendered that are beyond those prior certified as medically/clinically necessary.**

If the hospital confinement extends beyond the number of prior certified days, the additional days will not be covered unless:

- The extension of days if medically/clinically necessary, and  
- Prior certification for the extension is obtained before exceeding the number of prior certified days.

For emergency admissions, the Benefit Administrator should be notified by the end of the next business day following the admission or as soon as reasonably possible.

The amount used to meet the individual deductible for each member of a family is also used in meeting the family deductible. Deductible and out-of-pocket amounts are applied in the order that claims are processed for payment.

The “out-of-pocket limit” is the total amount of deductible (if any), coinsurance and copayments for covered services, including covered prescription drug services, that you will pay during the plan year, except as described below.

Amounts paid for any of the following will not apply toward the out-of-pocket limit. You will be responsible for the following expenses even after the out-of-pocket limit has been reached:

- 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.

Coverage maximums up to a certain number of days or visits per plan year are reached by combining either Choice or Standard Benefits up to the limit for one or the other but not both. (Example: If the Choice Benefit is for 60 visits and the Standard Benefit is for 60 visits, the maximum benefit is 60 visits, not 120 visits.)