Network Benefits are provided by network providers (except as otherwise provided by this SPD), and may require prior certification with the Benefit Administrator (except in a medical emergency). For a current status of Priority Health network providers, call the Customer Service Department at 616-956-1954 or 800-956-1954. A listing of Priority Health network providers is also available on the Internet at priorityhealth.com. For employees residing outside the Priority Health service area additional networks are available: A listing of First Health providers is available on the Internet at www.myfirsthealth.com. A PHCS/Multiplan provider listing is available by contacting PHCS/Multiplan at 888-440-7427 or checking the listing online at multiplan.com. A UPHP Regional Network provider listing is available by contacting UPHP at 800-835-2556 or checking the listing online at UPHP.com.

Non-Network Benefits are provided by non-network providers. Services may require the satisfaction of deductibles and coinsurance amounts, and are subject to reasonable and customary charges. Some benefits must be prior certified with the Benefit Administrator (except in a medical emergency).

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. For emergency admissions, you must notify the Benefit Administrator as soon as reasonably possible after admission. You or your physician must call 800-269-1260 to prior certify services. If you are receiving intensive treatment for mental health services, including inpatient hospitalization and partial hospitalization, you must notify the Behavioral Health Department as soon as possible for assistance. Call the Behavioral Health department at 616-464-8500 or 800-673-8043 for assistance. You do not need prior approval from Benefit Administrator 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
- Certain Surgeries and Treatments

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.

Network deductible, coinsurance and out-of-pocket amounts do not apply to non-network deductible, coinsurance and out-of-pocket amounts, and, non-network deductibles, coinsurance and out-of-pocket amounts do not apply to network deductible, coinsurance and out-of-pocket amounts.

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>NETWORK BENEFITS</th>
<th>NON-NETWORK BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500 per individual</td>
<td>$1,000 per individual</td>
</tr>
<tr>
<td></td>
<td>$1,000 per employee +1</td>
<td>$2,000 per employee +1</td>
</tr>
<tr>
<td></td>
<td>$1,500 per family</td>
<td>$3,000 per family</td>
</tr>
<tr>
<td>Benefit Percentage Rate</td>
<td>80% paid by the plan; 20% paid by the participant, unless otherwise noted.</td>
<td>60% paid by the plan; 40% paid by the participant, unless otherwise noted.</td>
</tr>
<tr>
<td>Coinsurance Maximums</td>
<td>$2,500 per individual</td>
<td>$5,000 per individual</td>
</tr>
<tr>
<td>(Does not include deductible or copayment expenses.)</td>
<td>$5,000 per employee +1</td>
<td>$10,000 per employee +1</td>
</tr>
<tr>
<td></td>
<td>$7,500 per family</td>
<td>$15,000 per family</td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td>$4,000 per individual</td>
<td>$8,000 per individual</td>
</tr>
<tr>
<td>(Includes deductible, coinsurance and copayment expenses.)</td>
<td>$8,000 per employee +1</td>
<td>$16,000 per employee +1</td>
</tr>
<tr>
<td></td>
<td>$12,000 per family</td>
<td>$24,000 per family</td>
</tr>
<tr>
<td>Reduction of Benefits Penalty</td>
<td>Not applicable.</td>
<td>$250 penalty applies if not prior certified.</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 at [priorityhealth.com](http://priorityhealth.com) or you may request a copy from the Customer Service Department. Priority Health’s Guidelines include preventive services required by legislation.

<table>
<thead>
<tr>
<th>Medical Office Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office/Home Visits and Consultations</strong> (Includes visits not listed in Priority Health’s Preventive Health Care Guidelines or routine maternity services)</td>
<td>$30 copayment per visit for Primary Care Provider (PCP)</td>
<td>Covered at 60% after deductible</td>
</tr>
<tr>
<td>Primary Care Providers include pediatricians, family practice, internists and select OB/gynecologists.</td>
<td>$60 copayment per visit for Specialty Care Provider (SCP) (Includes face-to-face, telephonic, or through secure electronic portal). Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td><strong>Virtual Visits</strong></td>
<td>$30 copayment per visit. Deductible does not apply.</td>
<td>Not Applicable.</td>
</tr>
<tr>
<td>(For virtual visits placed through the Priority Health Member Center)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office Surgery</strong></td>
<td>Covered at 100% deductible does not apply.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td><strong>Office Injections</strong></td>
<td>Covered at 100% deductible does not apply.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td><strong>Allergy Services</strong> (Including allergy testing, evaluations and injections, including serum costs.)</td>
<td>Covered at 100% deductible does not apply.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td><strong>Diagnostic Radiology and Lab Services</strong> (Performed in physician’s office.)</td>
<td>Covered at 100% deductible does not apply.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>BENEFITS</td>
<td>NETWORK BENEFITS</td>
<td>NON-NETWORK BENEFITS</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Obstetrical Services by Physician (Including prenatal and postnatal care.)</td>
<td>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 delivery and nursery services.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Maternity Education Classes</td>
<td>Attendance at an approved maternity education program is covered in full. Deductible does not apply.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible. $250 penalty applies if not prior certified.</td>
</tr>
<tr>
<td>Dietitian Services (Other than as provided in Priority Health’s Preventive Health Care Guidelines.)</td>
<td>$60 copayment per visit up to a maximum of 6 visits per plan year. Deductible does not apply.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Education Services (Other than as provided in Priority Health’s Preventive Health Care Guidelines.)</td>
<td>$60 copayment. Deductible does not apply.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital and Inpatient Longterm Acute Care Services</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible. $250 penalty applies if not prior certified.</td>
</tr>
<tr>
<td>Inpatient Professional and Surgical Charges</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Human Organ Tissue Transplants</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Travel, Meals and Lodging Expenses Associated with Transplant Services Limited to $10,000 per transplant.</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Approved Clinical Trial Expenses (routine expenses related to approved clinical trial)</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Outpatient Hospital Care and Observation Care Services (Including ambulatory surgery center facility charges.)</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Outpatient Hospital Professional and Surgical Charges</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Hospital and Free Standing Facility Diagnostic Laboratory &amp; Radiology Services</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Hospital Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible. $250 penalty applies if not prior certified.</td>
</tr>
</tbody>
</table>
### BENEFITS

#### Certain Surgeries and Treatments
- **Reconstructive surgery:**
  - blepharoplasty of upper eyelids,
  - breast reduction,
  - panniculectomy*, rhinoplasty*, septrhinoplasty* 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**

Covered at 80% after deductible.
*Prior approval required for panniculectomy, rhinoplasty and septrhinoplasty.

Covered at 60% after deductible.
*Prior approval required for panniculectomy, rhinoplasty and septrhinoplasty.

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#### Weight Loss Services
- Physician-supervised weight loss programs.
- Certain surgical treatments – limit one per lifetime.

Prior approval required.

Covered at 80% after deductible.

Coverage is limited to one bariatric surgery per lifetime unless medically/clinically necessary to correct or reverse complications from a previous bariatric procedure.

Covered at 60% after deductible.

Coverage is limited to one bariatric surgery per lifetime unless medically/clinically necessary to correct or reverse complications from a previous bariatric procedure.

---

#### Medical Emergency and Urgent Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Benefit Level</th>
<th>Non-Network Benefit Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td>$100 copayment per visit after deductible, then covered at 80%. (Copayment waived if admitted.)</td>
<td>Paid at the Network Benefit Level.</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Covered at 80% after deductible.</td>
<td>Paid at the Network Benefit Level.</td>
</tr>
<tr>
<td><strong>Urgent Care Facility Services</strong></td>
<td>$35 copayment per visit. Deductible does not apply.</td>
<td>Covered at 60% after deductible.</td>
</tr>
</tbody>
</table>

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#### 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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Benefit Level</th>
<th>Non-Network Benefit Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Mental Health &amp; Substance Abuse Services</strong> (Including subacute residential treatment facility and partial hospitalization.)</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Prior certification required except in emergencies.</td>
<td></td>
<td>$250 penalty applies if not prior certified.</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health &amp; Substance Abuse Services</strong> (Including medication management visits.)</td>
<td>$30 copayment per visit. All other office services covered at 100%. Deductible does not apply.</td>
<td>Covered at 60% after deductible.</td>
</tr>
</tbody>
</table>
### BENEFITS

<table>
<thead>
<tr>
<th>NETWORK BENEFIT</th>
<th>NON-NETWORK BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered at 80% after deductible. Office visit copayments may apply.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Covered at 80% after deductible. Office visit copayments may apply.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Covered at 100%, deductible waived when performed at outpatient facilities.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Covered at 100%, deductible waived.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>$60 copayment up to a benefit maximum of 60 visits per plan year. Deductible does not apply.</td>
<td>Covered at 60% after deductible up to a benefit maximum of 60 visits per plan year.</td>
</tr>
<tr>
<td>$60 copayment up to a benefit maximum of 30 visits per plan year. Deductible does not apply.</td>
<td>Covered at 60% after deductible up to a benefit maximum of 30 visits per plan year.</td>
</tr>
<tr>
<td>$60 copayment per visit. Deductible does not apply. Prior Approval required for ABA.</td>
<td>Covered at 60% after deductible. Prior Approval required for ABA.</td>
</tr>
<tr>
<td>$30 copayment for office visit and/or spinal manipulations. Limited to a maximum of 24 visits per plan year. X-rays covered at 80% after deductible.</td>
<td>Covered at 60% after deductible up to a maximum of 24 visits per plan year.</td>
</tr>
<tr>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible. $250 penalty applies if not prior certified.</td>
</tr>
<tr>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible. $250 penalty applies if not prior certified.</td>
</tr>
<tr>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible. $250 penalty applies if not prior certified.</td>
</tr>
<tr>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible. $250 penalty applies if not prior certified.</td>
</tr>
</tbody>
</table>
| **Family Planning and Reproductive Services**

- **Infertility Counseling & Treatment**
  - Covered for diagnosis and treatment of underlying cause only.
  - Covered at 80% after deductible. Office visit copayments may apply.
- **Vasectomy**
  - Covered only when performed in physician’s office or when in connection with other covered inpatient or outpatient surgery.
  - Covered at 80% after deductible. Office visit copayments may apply.
- **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 in full, 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.
- **Rehabilitative Medicine Services – Not related to Autism Treatment**
  - **Speech, Physical and Occupational Therapy** (Combined maximum for all services.)
  - **Cardiac Rehabilitation and Pulmonary Rehabilitation** Limitations apply. (Combined maximum for all services.)
  - **Services Related to the Treatment of Autism Spectrum Disorder** (Available for children and adolescents through the age of 18 only)
  - **Physical, Occupational and Speech Therapy; Applied Behavioral Analysis (ABA) for Autism Treatment.**
  - **Other Services**

- **Chiropractic Services**
  - **Durable Medical Equipment** Prior certification is required for charges over $1,000.
  - **Prosthetic & Orthotic/Support Devices** Prior certification is required for charges over $1,000.
  - **Temporomandibular Joint Syndrome (TMJS) Treatment**
  - **Orthognathic Surgery & Treatment**
### BENEFITS

#### Other Services (Continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accidental Dental</strong></td>
<td>Paid at the applicable benefit level of the service rendered.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Treatment must be completed within 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>months from date of accident. Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>implants are not covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing and Inpatient</strong></td>
<td>Covered at 80% after deductible up to a maximum of 60 days per plan year.</td>
<td>Covered at 60% after deductible up to a maximum of 60 days per plan year.</td>
</tr>
<tr>
<td>Rehabilitation Facilities</td>
<td></td>
<td>$250 penalty applies if not prior certified.</td>
</tr>
<tr>
<td>Prior certification required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Combined maximum for all services.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Services</strong> (Including</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>hospice services, excluding rehabilitative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>medicine.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior certification required.</td>
<td>Covered at 100%. Deductible does not apply.</td>
<td>$250 penalty applies if not prior certified.</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Prior certification required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Hemodialysis, Radiation Therapy and</td>
<td>Covered at 80% after deductible.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Chemotherapy**</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Services</strong></td>
<td>Paid at the applicable benefit level of the service rendered.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Covered for treatment of medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>conditions and diseases of the ear only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing aids are not covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eye Care</strong></td>
<td>Paid at the applicable benefit level of the service rendered.</td>
<td>Covered at 60% after deductible.</td>
</tr>
<tr>
<td>Covered for treatment of medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>conditions and diseases of the eye only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refractive errors and vision supplies are not covered.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Vision and hearing benefits may be available – contact your Human Resources department for more information.

#### Pharmacy Benefits – Participating Pharmacies

<table>
<thead>
<tr>
<th>Category</th>
<th>Retail Pharmacy (up to 31 day supply):</th>
<th>Retail or Mail Service Program (up to 90 day supply):</th>
<th>Specialty Pharmacy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs – Managed Formulary</td>
<td>Generic Drugs: $10 copayment</td>
<td>Generic Drugs: $20 copayment</td>
<td>Preferred Specialty Drugs: 20% copayment up to a maximum of $200 per fill</td>
</tr>
<tr>
<td>Includes disposable needles and syringes for diabetics. Insulin pen</td>
<td>Preferred Brand Name Drugs: $40</td>
<td>Preferred Brand Name Drugs: $80 copayment</td>
<td>Non-Preferred Specialty Drugs: 50% copayment up to a maximum of $400 per fill</td>
</tr>
<tr>
<td>needles to be dispensed as a tier 1 benefit. Sexual dysfunction</td>
<td>copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>medication limited to 12 pills per month. Any medications provided in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the Priority Health’s Preventive Health Care Guidelines, including certain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>women’s prescribed contraceptive methods are covered at 100%, copayments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>waived. Brand-name contraceptives (except those without a generic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>equivalent) are subject to applicable copayments. Infertility medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>are not covered.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Medical Plan Pharmacy Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Preferred Specialty Drug: 20% copayment up to a maximum per injection or infusion of $200.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs Requiring Administration by a Health Professional (Injectable and</td>
<td>Non-Preferred Specialty Drug: 50% copayment up to a maximum per injection or infusion of $400.</td>
</tr>
<tr>
<td>infusible drugs requiring administration by a health professional in a</td>
<td></td>
</tr>
<tr>
<td>medical office, home or outpatient facility)</td>
<td></td>
</tr>
<tr>
<td>Prior approval required.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy.</td>
</tr>
</tbody>
</table>

MDA Health Plan
PPO Plan 500 Option 1

Effective March 1, 2017
Group number #789638
### Travel Network Benefit

| Submit Claims for the Travel Network to: | When medical care is needed while traveling outside the Priority Health service area, benefits will be paid at the network level when you use a PHCS or Multiplan provider. For current provider listing, please contact PHCS/Multiplan at the following: |
| Priority Health Managed Benefits, Inc. P.O. Box 232 Grand Rapids, MI 49501-0232 | Phone Line: 888-785-7427 Website: multiplan.com |

### Coverage Information

| Waiting Period Requirement | As shown in the Schedule of Eligibility of the plan. |
| Full-Time Employee | As shown in the Schedule of Eligibility of the plan. |
| Retiree Coverage | Not applicable. |
| Dependent Children | Covered up to the end of the calendar year in which they turn age 26. Over age 26 if mentally or physically incapacitated dependent. |
| Motor Vehicle Injuries | This plan coordinates benefits with any available motor vehicle policy. |
| Motorcycle Injuries | This plan is secondary to motorcycle insurance. |

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.

**If you seek services when prior certification is required and you do not receive prior certification, except in emergencies, you will be charged a penalty. You will also 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 is 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. Flat dollar copays, including pharmacy copays, do not apply in meeting the deductible amount.

The “out-of-pocket limit” is the total amount of deductible, coinsurance and copayments for covered services, including covered prescription drug services, that you will pay during the plan year, except as described below. If the individual annual out-of-pocket limit is reached during a plan year, the plan will pay 100% of covered expenses incurred by that person for the rest of the plan year. If the family out-of-pocket limit is reached during a plan year, the plan will pay 100% for the employee and all of the employee’s covered dependents for the rest of the plan year. Amounts paid for any of the following will not apply toward the out-of-pocket limit and you will be responsible for the following expenses even after the out-of-pocket limit has been reached:

- any monies you paid to providers for non-network benefits that exceed reasonable and customary; and
- any monies you paid for non-covered services; and
- any monies for prior certification penalties; 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 network or non-network benefits up to the limit for one or the other but not both. (Example: If the network benefit is for 60 visits and the non-network benefit is for 60 visits, the maximum benefit is 60 visits, not 120 visits.)