PriorityHealth

PriorityHMO℠

Schedule of Copayments & Deductibles Certificate Riders

Read Immediately: Important information about your Priority Health benefits

Filed in Michigan

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Schedule of Copayments and Deductibles

HMO - 100% HOSPITAL SERVICES PLAN

Your Certificate of Coverage provides you with important information about your health care benefits, including Prior Authorization requirements. This Schedule of Copayments and Deductibles provides you with information about your costs when you receive health care services and the maximum limitations of your health care benefits. Read the entire Certificate and Schedule of Copayments and Deductibles carefully.

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

A. Medically/Clinically Necessary (as defined in the Certificate 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. Provided by your PCP or provided by a Participating Provider upon and with authorization in advance by us when we consider authorization necessary (except in a Medical Emergency) or provided by a Non-Participating Provider (one not listed in our Provider Directory) upon referral from your PCP and approved in advance by us (except in a Medical Emergency); or
C. Provided outside of the Service Area but within the United States to a Covered Dependent child who resides outside the Service Area (Reasonable and Customary limitations apply); and
D. Not excluded in the Certificate or a Rider or an amendment to the Certificate.

If you seek such services without receiving Prior Authorization from us when required, you will be responsible for the full cost of the services. You will also be responsible for the full cost of services that are beyond those authorized, beyond benefit maximums or excluded from Coverage. **You or your Physician must call 800.269.1260 to obtain Prior Authorization for services. Emergency admissions must be reported to us as soon as reasonably possible after admission.**

The complete and detailed list of services that require a Prior Authorization is available by calling our Customer Service Department or on our website at *priorityhealth.com*. This list may change throughout the Contract Year as new technology and standards of care emerge.

See Section 6 of your Certificate for Covered and Non-Covered Services, including the summary of Covered preventive health care services. Priority Health's complete Preventive Health Care Guidelines are available in our Member Center on our website at *priorityhealth.com*, or you may request a copy from our Customer Service Department.

DEDUCTIBLES

Your Plan may have a Deductible. A Deductible is the amount you must pay before Priority Health will pay for Covered Services under this Certificate. The following services are not subject to the Deductible:

- **Routine maternity care (the Deductible does apply to facility charges for delivery).**
- **Services received in your PCP's office during regular office hours,**
- **Services billed by your PCP's office,**
- **Virtual Care services placed through your Member Center at *priorityhealth.com* or with other Participating Providers,**
- **Mental health outpatient services visits,**
- **Substance use disorder outpatient services visits, and**
- **Preventive health care services. See Section 6.A.1 of your Certificate for Covered and Non-Covered Services, including the summary of Covered preventive health care services. Priority Health's complete Preventive Health Care Guidelines are available in our Member Center on our website at *priorityhealth.com*, or you may request a copy from our Customer Service Department.**

The Deductible does not apply to covered services that have been added by a Rider when the Rider adds coverage beyond the Certificate. For example, the Deductible does not apply to the prescription drug Rider. The Deductible does apply to covered services that have been added by a Rider when the Rider changes the benefit limit listed in the Certificate and the Schedule of Copayments and Deductibles.

Deductibles	
Individual Contract	Not applicable
Family Contract	Not applicable

MAXIMUMS AND OUT-OF-POCKET LIMITS

A. Coinsurance Maximums:

The Coinsurance Maximum applies to Covered Services except those listed below. The Coinsurance Maximum limits the total amount of Coinsurance for Covered Services that you will pay during a Contract Year, except as described below.

Coinsurance Maximums	
Individual	Not applicable
Family	Not applicable

B. Out-of-Pocket Limits:

The Out-of-Pocket Limit is the total amount of Deductible (if any), Coinsurance and Copayments for Covered Services that you will pay during a Contract Year, except as described below. If your plan includes a Prescription Drug Rider, the Out-of-Pocket Limit also includes the total amount of prescription drug Deductible (if any), Coinsurance and Copayments for prescription drug Covered Services that you will pay during a Contract Year, except as described below.

Out-of-Pocket Limits	
Individual	$ 8,150.00 per Contract Year
Family	$16,300.00 per Contract Year (but not to exceed the Individual Out-of-Pocket Limit per person)

Amounts paid for any of the following will not apply toward the Out-of-Pocket Limit. Your cost sharing (Copayment or Coinsurance) applies to these services 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.

If the individual Out-of-Pocket Limit is reached during a Contract Year, Priority Health will pay 100% of the contracted rate for Covered Services incurred for the rest of the Contract Year. If the family Out-of-Pocket Limit is reached during a Contract Year, Priority Health will pay 100% of the contracted rate for Covered Services incurred by you and all your Covered Dependents for the rest of the Contract Year.

Your Out-of-Pocket Limit renews each Contract Year.

Note: Deductibles, Copayments and Coinsurance you pay for any non-essential health benefit Covered Services obtained under a supplemental benefit Rider may not apply toward the above Coinsurance Maximum or Out-of-Pocket Limit.

Services	Benefits
Hospital Services (Including radiology examinations and laboratory services) (See Other Referral Care section below for additional Copayment information.)	
Hospital Inpatient Care and Inpatient Longterm Acute Care Services	• 100% Coverage • Prior Authorization 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
Hospital Outpatient Care and Hospital Observation Care Services (Including ambulatory surgery center facility charges. May also include office-based facility fees.)	• 100% Coverage • Prior Authorization is required
Medical Emergency and Urgent Care Services	
Emergency Room Services **Note**: If you are admitted for Hospital Inpatient Care or Hospital Observation Care from the emergency room, your emergency room charges will be paid under the Hospital Services categories above and the Emergency Room Services Copayment in this category does not apply.	• $150.00 Copayment per visit • Reasonable and Customary limitations apply for emergency room services provided by a Non-Participating Provider
Urgent Care Center Services	• $50.00 Copayment per visit (Copayment applies to all Urgent Care visits) • Reasonable and Customary limitations apply for Urgent Care Center services provided by a Non-Participating Urgent Care Center outside the Service Area. Urgent Care Center services by a Non-Participating Provider in the Service Area are *not* Covered.
Ambulance Services	• 100% Coverage • Reasonable and Customary limitations apply for ambulance services provided by a Non-Participating Provider
Physician Services (Primary and Referral Care) (See Other Referral Care section below for additional Copayment information.)	
Office/Home Visits and Consultations (Face-to-face visit) Includes visits *not* Covered under preventive health care services or routine maternity services	• $25.00 Copayment per visit, for all Covered Services performed during each visit by PCP, other Participating Physician and Referral • Prescription drug Copayment may also apply when selected injectable drugs are provided
Virtual Care Services (Telehealth includes telephonic and telemedicine) (Including medication management visits)	$10.00 Copayment per visit
Retail Health Clinic (Located within the United States)	$50.00 Copayment per visit for evaluation and management services only
Preventive Health Care Services -See Section 6.A.1 of your Certificate for the summary of Covered preventive health care services	Covered in full
Maternity Services (Prenatal and postnatal)	100% Coverage. Attendance at an approved maternity education program is Covered in full.
Inpatient Hospital Visits	Covered in full
Surgery	Covered in full
Ambulatory Surgery Center Services	Covered in full

Services	Benefits
Vasectomy	• Physician services Covered in full only when performed in 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
Tubal Ligation	• Physician services Covered in full • 100% Coverage for outpatient facility charges • 100% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery
Other Referral Care (Copayments are for all medical services including, but not limited to, Physician and Hospital services)	
Allergy Testing and Serum	100% Coverage
Allergy Injections	100% Coverage
Family Planning/Infertility Services (Limited Coverage)	• 100% Coverage for diagnostic, counseling and planning services for treatment of the underlying cause of infertility • Prescription drugs for infertility treatment Covered only with prescription drug Rider
Temporomandibular Joint Dysfunction or Syndrome	100% Coverage
Orthognathic Surgery	50% Coverage

Certain Surgeries and Treatments
• *Bariatric Surgery*
• Reconstructive surgery
  ○ Blepharoplasty of upper lids
  ○ Breast reduction
  ○ *Panniculectomy*
  ○ *Rhinoplasty*
  ○ *Septorhinoplasty*
  ○ 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
  ○ Port wine stain and hemangioma treatment
• Varicose veins treatments
• Sleep apnea treatment procedures
	• Physician fees are Covered at 100%. If applicable, any Hospital services Copayment also applies.
	• *Prior Authorization required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty*
	• ***Coverage is limited to one bariatric surgery per lifetime. Unless Medically/Clinically Necessary, a second bariatric surgery is not Covered, even if the initial bariatric surgery occurred prior to Coverage under this plan.***

Services	Benefits
Behavioral Health Services Prior Authorization by our Behavioral Health Department is required as noted. Call 616 464-8500 or 800 673-8043	
Mental Health Inpatient Care (Including Residential Treatment facility and partial Hospitalization)	• 100% Coverage • Except in an emergency, Prior Authorization required
Mental Health Outpatient Care (Face-to-face visit)	100% Coverage
Substance Use Disorder Inpatient Care (Including subacute Residential Treatment facility)	• 100% Coverage • Except in an emergency, Prior Authorization required
Substance Use Disorder Outpatient Care (Face-to-face visit)	100% Coverage
Rehabilitative Medicine Services (Not related to treatment of Autism Spectrum Disorder)	
Physical and Occupational Therapy (including osteopathic and chiropractic manipulation)	100% Coverage up to a combined benefit maximum of 60 visits per condition per Contract Year*
Speech Therapy	100% Coverage up to 60 visits per condition per Contract Year*
Cardiac and Pulmonary Rehabilitation	100% Coverage up to a combined benefit maximum of 60 visits per condition per Contract Year*
Services for the Treatment of Autism Spectrum Disorder (Available for Members under the age of 19 only)	
Physical and Occupational Therapy for the Treatment of Autism Spectrum Disorder	$25.00 Copayment per visit
Speech Therapy for the treatment of Autism Spectrum Disorder	$25.00 Copayment per visit
Applied Behavior Analysis (ABA) for the treatment of Autism Spectrum Disorder	• 100% Coverage • Prior Authorization required for Applied Behavior Analysis

Services	Benefits
Other Services	
Advanced Diagnostic Imaging Services (such as CT, CTA, MRI, MRA, Nuclear Cardiology Studies, PET Scan)	• 100% Coverage • Prior Authorization is required for certain radiology examinations
Radiology Examinations and Laboratory Procedures (In a non-Hospital facility)	• 100% Coverage • Prior Authorization required for genetic testing
Prosthetic and Orthotic/Support Devices	• 100% Coverage • Prior Authorization required for devices over $1,000.00 and all shoe inserts
Durable Medical Equipment (DME) (Rent, purchase or repair)	• 100% Coverage • Prior Authorization required for equipment over $1,000.00 and all rentals
Non-Hospital Facility Services Including Skilled Nursing Care services received in a: • Skilled Nursing Care facility • Subacute facility • Inpatient Rehabilitation Care facility • Hospice Care facility	• 100% Coverage up to the benefit maximum of 730 days per Lifetime • Prior Authorization required, except for Hospice Care services in a Hospice Care facility
Home Health Care (Including Hospice Care services, excluding Rehabilitative Medicine Services) **Note:** Rehabilitative Medicine Services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described above	• 100% Coverage • Prior Authorization required, except for Hospice Care services in the home

MAXIMUM LIMITATIONS

* **Benefit Maximums:** Benefit maximums up to a certain number of days/visits per Contract Year apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

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HMO - OUT-OF-AREA DEPENDENT CHILD BENEFIT

This Out-of-Area Dependent Child benefit schedule is designed for a Covered Dependent child or children who are living outside of Priority Health's Service Area and within the United States. The benefit schedule applies in certain circumstances described in item 3 below.

(**Note:** Dependent Children who are *living outside of the United States* are covered for Medical Emergencies and Urgent Care Services only.)

1. If you are a Covered Dependent child living and/or receiving services *within* Priority Health's Service Area, services are Covered at the Employer benefit level as listed in your Schedule of Copayments and Deductibles.
2. If you are a Covered Dependent child living *outside* the Service area but *within* the United States and services are provided by a Priority Health leased Network Provider located outside the Service Area but within the United States, services are Covered at the Employer benefit level as listed in your Schedule of Copayments and Deductibles.
3. If you are a Covered Dependent child living *outside* the Service area but *within* the United States, services are Covered at the Out-of-Area Dependent Child Benefit Copayments as listed in the benefit schedule below when services are provided by a Non-Participating Provider.

OUT-OF-AREA DEPENDENT CHILD BENEFIT COPAYMENTS FOR ITEM 3. ABOVE.

If your Plan has a Deductible, the Deductible will apply to the same Covered Services that are detailed in your Schedule of Copayments and Deductibles or Deductible Rider.

Services	Benefits
Hospital Services (Including facility-based Physician services, radiology examinations and laboratory services) (See Other Referral Care section below for additional Copayment information.)	
Hospital Inpatient Care and Inpatient Longterm Acute Care Services	• Prior Authorization by Priority Health is required except for Medical Emergencies and inpatient Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. You may be directed into the Priority Health Service Area if medically appropriate for some non-emergency services. Inpatient Hospital services received out of the Service Area that are authorized in advance by Priority Health are Covered at the Employer benefit level. Reasonable and Customary limitations apply. • Emergent inpatient Hospital services are Covered at the Employer benefit level.
Hospital Outpatient Care and Hospital Observation Care Services (Including ambulatory surgery center facility charges. May also include office-based facility fees.)	• 70% Coverage of Reasonable and Customary Charges • Prior Authorization required for certain radiology examinations.
Medical Emergency and Urgent Care Services	
Emergency Room Services NOTE: If you are admitted for Hospital Inpatient Care or Hospital Observation Care from the emergency room, your emergency room charges will be paid under the Hospital Services categories above and the Emergency Room Services Copayment in this category does not apply.	• Employer benefit level. (Copayment waived only if you become confined in a Hospital as an inpatient) • Coverage includes one follow up visit within 60 days after an emergency room visit at the Employer benefit level • 70% Coverage of Reasonable and Customary Charges for ongoing treatment after emergent care

Services	Benefits
Urgent Care Center Services	• Employer benefit level. Reasonable and Customary limitations apply. • 70% Coverage of Reasonable and Customary Charges for ongoing treatment after Urgent Care
Ambulance Services	Employer benefit level
Physician Services **(Primary and Referral Care)** (See Other Referral Care section below for additional Copayment information.)	
Office/Home Visits and Consultations - Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits) (Preventive Health Services Covered in Service Area only at Employer benefit level)	• 70% Coverage of Reasonable and Customary Charges • Prescription drug Copayment may also apply when selected injectable drugs are provided
Virtual Care Services	Covered in full
Retail Health Clinic (Located within the United States)	70% Coverage of Reasonable and Customary Charges
Inpatient Hospital Visits and Professional Services	70% Coverage of Reasonable and Customary Charges
Surgery	70% Coverage of Reasonable and Customary Charges
Ambulatory Surgery Center Services	70% Coverage of Reasonable and Customary Charges
Maternity Services (Prenatal and postnatal)	70% Coverage of Reasonable and Customary Charges
Voluntary Sterilization	Covered in Service Area only at Employer benefit level
Allergy Testing and Serum	70% Coverage of Reasonable and Customary Charges
Allergy Injections	100% Coverage of Reasonable and Customary Charges
Other Referral Care (Copayments are for all medical services including, but not limited to, Physician and Hospital services)	
Family Planning/Infertility Services (Limited Coverage)	Covered in Service Area only at Employer benefit level
Temporomandibular Joint Dysfunction or Syndrome	Covered in Service Area only at Employer benefit level
Orthognathic Surgery	Covered in Service Area only at Employer benefit level

Services	Benefits

Certain Surgeries and Treatments (Physician fees only)
• *Bariatric surgery*
• Reconstructive surgery
  o Blepharoplasty of upper lids
  o Breast reduction
  o *Panniculectomy*
  o *Rhinoplasty*
  o *Septorhinoplasty*
  o Surgical treatment of male gynecomastia
• Skin disorder treatments
  o Scar revisions
  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
• Varicose veins treatments
• Sleep apnea treatment procedures
	• 70% Coverage of Reasonable and Customary Charges for Physician fees
	• See the Hospital Services Section for facility coverage related to certain surgeries and treatments
	• *Prior Authorization required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty*
	• ***Coverage is limited to one bariatric surgery per lifetime. Unless Medically/Clinically Necessary, a second bariatric surgery is <u>not</u> Covered, even if the initial bariatric surgery occurred prior to Coverage under this plan.***

Behavioral Health Services Prior Authorization by our Behavioral Health Department is required as noted. Call 616 464-8500 or 800 673-8043.	
Mental Health Inpatient (Including Residential Treatment facility and partial Hospitalization)	• 70% Coverage of Reasonable and Customary Charges • Except in an emergency, Prior Authorization required
Mental Health Outpatient - Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits)	70% Coverage of Reasonable and Customary Charges
Substance Use Disorder Inpatient Care (Including Residential Treatment facility and partial Hospitalization)	• 70% Coverage of Reasonable and Customary Charges • Except in an emergency, Prior Authorization required
Substance Use Disorder Outpatient Care - Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits)	70% Coverage of Reasonable and Customary Charges
Rehabilitative Medicine Services (Not related to treatment of Autism Spectrum Disorder)	
Physical and Occupational Therapy	50% Coverage of Reasonable and Customary Charges up to a combined benefit maximum of 30 visits per Contract Year*
Osteopathic and Chiropractic Manipulation Therapy (Including maintenance manipulations)	50% Coverage of Reasonable and Customary Charges up to a combined benefit maximum of 30 visits per Contract Year*

Services	Benefits
Speech Therapy	50% Coverage of Reasonable and Customary Charges up to a benefit maximum of 30 visits per Contract Year*
Cardiac Rehabilitation and Pulmonary Rehabilitation	50% Coverage of Reasonable and Customary Charges up to a combined benefit maximum of 30 visits per Contract Year*
Services for the Treatment of Autism Spectrum Disorder (Available for Members under the age of 19 only)	
Physical and Occupational Therapy for the Treatment of Autism Spectrum Disorder	• 50% Coverage of Reasonable and Customary Charges
Speech Therapy for the treatment of Autism Spectrum Disorder	• 50% Coverage of Reasonable and Customary Charges
Applied Behavior Analysis (ABA) for the treatment of Autism Spectrum Disorder	• 50% Coverage of Reasonable and Customary Charges • Prior Authorization required for Applied Behavior Analysis
Other Services	
Advanced Diagnostic Imaging Services (such as CT, CTA, MRI, MRA, Nuclear Cardiology Studies, PET Scan)	• 70% Coverage of Reasonable and Customary Charges • Prior Authorization is required for certain radiology examinations
Standard Radiology Examinations and Laboratory Procedures (In a non-Hospital facility or Physician's office)	• 70% Coverage of Reasonable and Customary Charges • Prior Authorization required for genetic testing
Prosthetic and Orthotic/Support Devices	• Employer benefit level. Reasonable and Customary limitations apply. • Prior Authorization required for devices over $1,000.00 and all shoe inserts
Durable Medical Equipment (Rent, purchase or repair)	• Employer benefit level. Reasonable and Customary limitations apply. • Prior Authorization required for equipment over $1,000.00 and all rentals
Non-Hospital Facility Services - including Skilled Nursing Services received in a: • Skilled nursing facility • Sub-acute facility • Inpatient rehabilitation facility • Hospice facility	• 70% Coverage of Reasonable and Customary Charges up to the benefit maximum of 45 days per Contract Year * • Prior Authorization required, except for Hospice Care services in a Hospice Care facility
Home Health Care (Including Hospice Care Services, excluding Rehabilitative Medicine Services) **Note:** Rehabilitative Medicine Services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described above	• 70% Coverage of Reasonable and Customary Charges • Prior Authorization required, except for Hospice services in the home

Services	Benefits
Prescription Drugs	Employer benefit level applies if the Employer provides Prescription Drug Coverage. (Approved drug list rules apply)
Eye Care	70% Coverage of Reasonable and Customary Charges for medical diseases of the eye only
Hearing Care	Coverage not available
Custodial Care/Private Duty Nurse/Home Health Aides	Coverage not available

MAXIMUMS AND OUT-OF-POCKET LIMITS

Benefit Maximums:

* **Benefit Maximums:** Benefit maximums up to a certain number of days/visits per Contract Year apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum. The maximum number of days or visits per Contract Year may vary. Please refer to your Schedule of Copayments and Deductibles or Riders for details.

If your plan includes Coinsurance Maximums, any Coinsurance Maximums described in the Schedule of Copayments and Deductibles *do not* apply to Covered Services Obtained under this Out-of-Area Child Benefit.

Out-of-Pocket Limits described in the Schedule of Copayments and Deductibles *do* apply to Covered Services obtained under this Out-of-Area Dependent Child Benefit.

This Rider supersedes any amendment or Rider regarding an Out-of-Area Dependent Child Benefit (including an Out-of-Area Student Continuation Benefit) previously issued by us. If there is any conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate will remain in full force and effect.

Nothing contained in this Rider varies, alters, waives, or extends any of the terms, conditions, provisions, or limitations of the Certificate other than as stated above.

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Certificate Riders

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

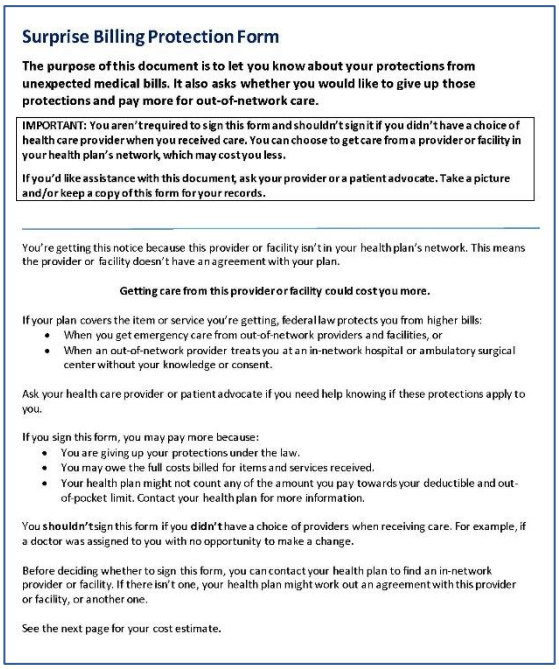
Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent *(see sample notice at right)* and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

In addition, an out-of-network provider must provide a good-faith estimate of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.



Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

You also have a right to request that the health care services be performed by a provider that participates with your health benefit plan. You may contact Priority Health to arrange for those services to be provided at a lower cost and to receive information on in-network providers who can perform the health care services that you need.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, or you did not receive the required disclosure form, please contact Priority Health at the number on the back of your Member ID card. Unresolved issues can be directed to the Michigan Department of Insurance and Financial Services Monday through Friday 8 a.m. to 5 p.m. at 877.999.6442 or visit the DIFS website to file a complaint. Unresolved issues related to air ambulance services, plan members of self-funded groups, or plan members residing outside of Michigan can contact the CMS/Centers for Medicare and Medicaid Services at 800.985.3059 or visit *cms.gov/nosurprises/consumers*.

Visit *priorityhealth.com/landing/surprise-billing* for more information about your rights under state and federal law.

Doc-2022-6113

HMO - PRESCRIPTION DRUG WITH CONTRACEPTIVES

COPAYMENTS: $6.00 GENERIC / $13.00 BRAND NAME / $19.00 SEXUAL DYSFUNCTION DRUG

CLOSED FORMULARY

The following is a summary of the Coverage provided by the Prescription Drug Rider which has been made a part of the Agreement between Ford Motor Company and Priority Health.

The following Coverage is subject to all of the terms and conditions in your Certificate as well as the terms and conditions set forth in this summary.

1. DEFINITIONS

Approved Drug List. 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.

Brand Name Drug. A prescription drug approved by the Food and Drug Administration (FDA) that is protected by a patent, supplied by a single company and marketed under the manufacturer's brand name.

Generic Drug. A prescription drug approved by the Food and Drug Administration (FDA) that is produced and distributed without patent protection and contains the same active ingredient as the Brand Name Drug.

Participating Pharmacy. A Pharmacy that contracts with the pharmacy benefit manager as designated by Priority Health to provide Covered Services to Members. Our network includes Pharmacies in our service areas. We also have a national network of Pharmacies for out-of-area services. Names of Participating Pharmacies can be found in your *Provider Directory* or on our website at *priorityhealth.com*.

Pharmacy. An establishment where prescription drugs are legally dispensed.

Specialty Drugs. Drugs listed on the Approved Drug List 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 Drugs are limited to a maximum of a 34-day supply per prescription or refill.

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

2. COVERED SERVICES

In general, drugs are treated as prescription drug benefits under this Prescription Drug Rider when they can be self-administered, regardless of the setting. Exceptions to this rule are outlined in our medical policies.

Coverage provided by this Rider is based on the usage of our Approved Drug List. Drugs are added to, or removed from, the Approved Drug List on a regular basis. Some drugs require Prior Authorization. A prescriber may submit a Prior Authorization request. These requests will be reviewed by Priority Health clinical staff on a case by case basis, and Coverage may be authorized upon review by us.

We expect our Approved Drug List will meet all Members' prescription drug needs. Some drugs on the Approved Drug List require Prior Authorization by us. Also, if a Participating Physician prescribes a non-formulary drug, that drug may be Covered, if approved upon review by us. Priority Health will provide notice of its determination within 24 hours of receiving all information necessary to make the determination.

If you are not happy with the determination, you or your representative have the right to request a decision by an Independent Review Organization (IRO). Priority Health has 72 hours to obtain the IRO decision or 24 hours to obtain the IRO decision if waiting 72 hours may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.

Priority Health will Cover the non-formulary drug during the review period and for as long as required by law.

With a prescription order, written by a prescriber, we will Cover (a) outpatient prescription drugs that require a prescription and are listed in our Approved Drug List, or (b) drugs listed in Priority Health's Preventive Health Care Guidelines. All drugs must be dispensed by a Participating Pharmacy, including our designated mail order Pharmacy.

We will Cover outpatient prescription drugs dispensed by a non-Participating Pharmacy during a Medical Emergency or Urgent Care situation, as defined in Section 5 of the Certificate.

Covered outpatient prescription drugs include some or all of the following:

- Federal legend drugs - medicinal substances available only through prescription.
- State-restricted drugs - medicinal substances which, according to state law, may only be dispensed by prescription.

- Compounded medications - medicinal substances compounded by the pharmacist which have at least one ingredient that is federal legend or state-restricted in a therapeutic amount.
- Injectable insulin and disposable syringes and needles for administration of injectable insulin; nonexperimental medication for controlling blood sugar and medication used in the treatment of ailments, infections or medical conditions of the foot, ankle or nails associated with diabetes. (Note: Diabetic supplies such as syringes, needles, lancets, and blood glucose test strips, can be purchased at a Participating Pharmacy and your applicable prescription drug Copayment will apply. These supplies can also be purchased at a participating Durable Medical Equipment (DME) provider and your DME Copayment will apply as listed in the Schedule of Copayments and Deductibles.)
- Selected Specialty Drugs in certain categories, including but not limited to, arthritis injections, growth hormone injections, hepatitis C injections, migraine injections, multiple sclerosis injections, and oral oncology drugs are Covered under this Rider when obtained from a Participating Specialty Pharmacy.
- Women's prescribed and emergency contraceptive drugs and devices, such as birth control pills, diaphragms, and female condoms. Generic contraceptives (including generic emergency contraceptives) are Covered under preventive health care services at no cost share to you as outlined in Priority Health's Preventive Health Care Guidelines. A brand name contraceptive may be Covered under preventive health care services at no cost share to you when there is no generic equivalent for the same contraceptive method, or if authorized by Priority Health as Medically/Clinically Necessary. All other brand name contraceptive drugs are subject to the applicable Brand Name Drugs Copayment described below. Restrictions may apply to Members of (a) religious employer plans; (b) nonprofit religious employer plans; or (c) plans sponsored by closely held for profit companies with strong religious beliefs, which qualify for exemption under federal rules.
- Drugs for the treatment of sexual dysfunction, regardless of age, gender or health status. Drug treatment for sexual dysfunction consists of currently available FDA approved injectable, oral and intra-urethral pellet prescription drugs.
- Drugs used for the purpose of treating infertility.

3. COPAYMENTS

All Covered outpatient prescription drugs are subject to a Copayment. Read this entire section to determine your applicable Copayment.

Note: Drugs for the treatment of sexual dysfunction are subject to the Sexual Dysfunction Drugs Copayment regardless of if they are labeled as generic or brand name drugs.

- **Generic Drugs**
  $6.00 Copayment per prescription or refill for a Generic Drug (the "Generic Drugs Copayment").

  Generic Drugs dispensed by a mail order facility are subject to a $12.00 Copayment per prescription or refill.
- **Preferred Brand Name Drugs**
  $13.00 Copayment per prescription or refill for a preferred Brand Name Drug (the "Preferred Brand Name Drugs Copayment").

  Preferred Brand Name Drugs dispensed by a mail order facility are subject to a $26.00 Copayment per prescription or refill.
- **Non-Preferred Brand Name Drugs**
  $13.00 Copayment per prescription or refill for a non-preferred Brand Name Drug (the "Non-Preferred Brand Name Drugs Copayment").

  Non-preferred Brand Name Drugs dispensed by a mail order facility are subject to a $26.00 Copayment per prescription or refill.
- **Preferred Specialty Drugs**
  $13.00 Copayment for a preferred Specialty Drug (the "Preferred Specialty Drugs Copayment").
- **Non-Preferred Specialty Drugs**
  $13.00 Copayment for a non-preferred Specialty Drug (the "Non-Preferred Specialty Drugs Copayment").
- **Drugs for the Treatment of Sexual Dysfunction**
  $19.00 Copayment per prescription or refill for drugs for the treatment of sexual dysfunction (the "Sexual Dysfunction Drugs Copayment").

  Drugs for the treatment of sexual dysfunction dispensed by a mail order facility are subject to a $37.00 Copayment per prescription or refill.
- **Infertility Treatment**
  Drugs used for the purpose of treating infertility are subject to the Copayments described above.

The applicable Copayment must be paid at the time the prescription is dispensed.

If you elect to receive a Brand Name Drug when an equivalent Generic Drug is reasonably available, you may be responsible for the difference in cost between the Brand Name Drug and the Generic Drug. Any monies you paid for the difference in cost between a Generic Drug and the Brand Name Drug (because you elect to receive a Brand Name Drug when the prescription allows a Generic Drug substitution) are non-Covered services.

Determination of whether a drug is labeled as a generic or a brand name will be made by Medi-Span or other source nationally recognized in the retail prescription drug industry.

4. LIMITATIONS

A Participating Pharmacy may refuse to fill a prescription order or refill which, in the professional judgment of the pharmacist, should not be filled.

You may obtain up to a 34-day supply of medication at a retail Participating Pharmacy. A lesser-day supply may apply based on pre-packaged products. For example, based on dosing, an asthma inhaler may last for 25 days. In this instance, only one inhaler would be dispensed, since two inhalers would exceed the 34-day supply limit. Insulin is the exception to this rule and the quantity is rounded up or down based on dosing. For example, if a member needs one and one half vials for a 34-day supply, we will round up to two vials.

You may obtain up to a 90-day supply of medication (excluding Specialty Drugs) at one time for three applicable Copayments at a retail Participating Pharmacy. Retail Pharmacies participating in the 90-day supply program can be found in your *Provider Directory* or on our website at *priorityhealth.com*. The prescription must be written for a 90-day supply by the prescriber. Some medications may not be available in a 90-day supply due to storage or reconstitution requirements.

Medications needed on a long-term basis may be delivered postage paid, directly to your home through our mail service prescription drug program. A 90-day supply of medication is available through this service for the Copayments described in the Copayments Section of this Rider except in the case of Specialty Drugs or drugs that are prohibited by law (such as Accutane), or if your Group has purchased a different benefit design. Information on the prescription drug mail order program is available from our Customer Service Department or on our website at *priorityhealth.com*.

You may obtain a 34-day supply of insulin for one Copayment, or up to a 90-day supply of insulin at one time for three applicable Copayments. Insulin syringes may be dispensed up to a 34-day supply (maximum of 200 units) for one Copayment, or up to a 90-day supply (maximum of 600 units) for three applicable Copayments.

Certain Specialty Drugs requiring administration by a Health Professional in a medical office, home or outpatient facility are Covered under the medical plan instead of this Prescription Drug Rider.

The total amount of Copayments, Coinsurance and Deductibles that you will pay for all Covered Services under the plan has a limit. This limit is called the Out-of-Pocket Limit. Once you or your family has met the applicable Out-of-Pocket Limit, all prescription drug Covered Services will be Covered at no cost to you for the remainder of the Contract Year. The Schedule of Copayments and Deductibles and any Rider to the Certificate provide more information about the Out-of-Pocket Limit that will apply to you.

5. NON-COVERED SERVICES

- Except for drugs listed in Preventive Health Care Guidelines, drugs which do not, by federal or state law, require a prescription order (over-the-counter (OTC) drugs). We may elect to include certain OTC drugs on the Approved Drug List, based on recommendations made by our Pharmacy and Therapeutics Committee.
- Compound drugs that contain any bulk powders that are not authorized by Priority Health.
- Any legend drugs for which an over-the-counter (OTC) equivalent is available without a prescription order (such as, for example, Lotrimin).
- Schedule V controlled substances available without a prescription order.
- Therapeutic or testing devices, appliances, and medical supplies, support garments and other non-prescription supplies or substances regardless of their intended use.
- Injectable and infusible drugs administered by or under the supervision of a medical professional. (Note: Selected injectable and infusible drugs in certain categories are Covered by your medical Certificate.)
- Syringes, needles or disposable supplies, other than disposable syringes and needles prescribed with injectable insulin.
- Any charges for the administration of prescribed legend drugs or injectable insulin.
- Cosmetics or any drugs used for cosmetic purposes (such as, for example, drugs for the treatment of wrinkles, hair loss, and health or beauty aids).
- Testing reagents, insulin pumps and tubing for insulin pumps.
- Men's contraceptives.
- Multivitamins (except prenatal vitamins) and nutritional supplements, except when these are the only means of nutrition.
- Drugs used for the purpose of weight reduction, such as appetite suppressants.
- Any medication prescribed in a manner other than in accordance with our procedures.
- Prescription drugs for procedures and services that are not Covered Services, except for adult attention deficit disorders.
- Any medication which is consumed or administered at the place where it is dispensed.
- Replacement of lost or damaged prescriptions.

- Drugs for which no charge is made to the recipient. For example, if your Member cost is reduced by a Copayment assistance card, coupon or similar drug assistance program, only your Member cost share will accumulate toward your Deductible (if any) and your Out-of-Pocket Limit.
- Any drug labeled "Caution: Limited by Federal Law to Investigational Use," and any experimental drugs.
- Drugs not approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations.
- Prescription orders filled before the effective date or after the termination date of the Coverage provided by this Rider.
- Refills in excess of the amount specified by the prescriber, and any refill dispensed after one year from the order of the prescriber.
- Prescription drugs for which Coverage is excluded under this Rider.
- Specialty drugs in excess of a 34-day supply.

6. MISCELLANEOUS PROVISIONS

This Rider supersedes any amendment or Rider providing Coverage for outpatient prescription drug benefits previously issued by us. If there is any conflict between the provisions of this Rider and the Certificate, the provisions of this Rider shall prevail. All other terms and conditions of the Certificate shall remain in full force and effect.

Nothing contained in this Rider varies, alters, waives, or extends any of the terms, conditions, provisions, or limitations of the Certificate other than as stated above.

We will not be liable for any claim or demand for Injury or damage arising out of or in connection with the manufacturing, compounding, dispensing, or use of any prescription drug, or any other item, whether or not Covered by us.

Filed in Michigan: 2021

MidLgDoc-2021-5512

HMO - HEARING CARE

Ford Motor Company

The following is a summary of the Coverage provided by the Hearing Care Rider which has been made a part of the Agreement between Ford Motor Company and Priority Health.

The following Coverage is subject to all of the terms and conditions in the Certificate as well as the terms and conditions set forth in this summary.

1. DEFINITIONS

Hearing Care Provider. A PCP, other Participating Physician or a Specialist Provider who is certified as an otolaryngologist, otologist, or an otorhinolaryngologist who participates with us; or an audiologist certified in audiology, who participates with us at the written direction of the PCP, other Participating Physician or Specialist described above.

2. COVERED SERVICES

Coverage is provided for the following hearing care services and supplies:

(a) A hearing evaluation test performed by a Hearing Care Provider, upon approval by us, for the purpose of determining if a hearing problem exists.

(b) An audiometric examination and evaluation for a hearing aid prescription performed by a Hearing care Provider upon the referral of a Participating Physician.

(c) An electronic hearing aid installed in accordance with a prescription written by the PCP, other Participating Physician or Specialist.

(d) Maintenance services including adjustments.

3. COPAYMENT

No Charge. If your Plan has a Deductible, the Deductible does not apply to the hearing care services Covered by this rider.

4. LIMITATIONS

Coverage is limited to one hearing evaluation test, one audiometric examination, and one basic hearing aid per ear during any one period of 36 consecutive months.

Coverage is further limited to a benefit maximum of $1,000.00 per hearing aid per ear during any one period of 36 consecutive months.

We don't cover the cost of circuits (or add-ons).

5. NON-COVERED SERVICES

Except as otherwise provided above or in Section 6 of the Certificate, or as required under applicable state or federal law, Coverage isn’t provided for any of the following:

- Any care for or hearing examination to determine the presence of Illness or Injury, or any medical or surgical treatment for or drugs or medicines related to hearing problems performed by the audiologist or hearing aid dispenser.
- Batteries, replacement of lost, stolen or broken hearing aids, replacement parts and repairs for hearing aids, replacement of any hearing aid that was installed within the preceding 36-month period, and additional warranties extending the life of the hearing aid.
- Any hearing care services or supplies that don't meet professionally accepted standards or state and federal standards and any hearing aid that’s experimental or cosmetic in nature.

6. MISCELLANEOUS PROVISIONS

This Rider supersedes any amendment or Rider providing Coverage for hearing care previously issued by us. If there is any conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate will remain in full force and effect.

Nothing contained in this Rider varies, alters, waives, or extends any of the terms, conditions, provisions, or limitations of the Certificate other than as stated above.

Filed in Michigan: 2015

Doc_3757

HMO – ELECTIVE FIRST TRIMESTER PREGNANCY TERMINATION

The following is a summary of the Coverage provided by the Elective First Trimester Pregnancy Termination Rider which has been made a part of the Agreement between your Employer and us.

The following Coverage is subject to all of the terms and conditions in the Certificate as well as the terms and conditions set forth in this summary.

1. COVERED SERVICES

Coverage is provided for voluntary termination of pregnancy, as permitted by state and federal law, when performed at a facility that is a Participating Provider and occurring during the first trimester of the pregnancy. The services need not be provided by or referred from your PCP. But, your PCP and our Customer Service Department are available to direct you to a facility that is a Participating Provider for this Covered Service.

2. COPAYMENT

100%Coverage. If your Plan has a Deductible, the Deductible does not apply to elective first trimester pregnancy termination services Covered by this Rider.

3. LIMITATIONS

Coverage is limited to one procedure during any one period of 24 consecutive months.

4. MISCELLANEOUS PROVISIONS

This Rider supersedes any amendment or Rider providing Coverage for voluntary termination of pregnancy previously issued by us. If there is any conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate will remain in full force and effect.

This Rider doesn't carry any additional right to conversion beyond those rights provided in the Certificate.

Nothing contained in this Rider varies, alters, waives, or extends any of the terms, conditions, provisions, or limitations of the Certificate other than as stated above.

Filed in Michigan: 2020

Doc_2020-2843

PriorityRewards℠

As a Priority Health Member, you are eligible for **Priority**Rewards, a healthy lifestyle program designed to engage you in your health so you can make more informed decisions about your care.

This program is subject to the all the terms and conditions in your Priority Health Certificate, Policy or Agreement as well as the terms and conditions described in this amendment.

1. DEFINITIONS

The following definitions apply to the provisions described in this amendment:

Cost Estimator. A Priority Health online and mobile tool that allows you to look up the costs of services included on the Procedure List, view the locations performing those procedures in your area, and learn more about the procedure or service.

Fair Market Price. The amount an informed shopper should be expected to pay, taking into account the range of prices charged all across a geographic region.

Fair Market Price Facility. A facility location (1) charging a Fair Market Price for a service on the Procedure List in Cost Estimator; and (2) maintaining high quality standards. This provider's charges will be designated as a Fair Market Price in Cost Estimator.

Procedure List. A list of services described below that qualify you for a reward when performed at a Fair Market Price Facility. The Procedure List is available through Cost Estimator or by calling our Customer Service department at 800 446-5674.

2. HOW TO EARN YOUR REWARDS

Services that qualify you for cash rewards are limited to Covered Services in the Procedure List included below. Full cash rewards range from $50.00 to $200.00, depending on the service. Priority Health will send you a reward each time you earn a reward. However, you will not be eligible for more than one reward per procedure per day. In order to receive a reward, you must shop within the 6 month period prior to your procedure.

To earn a full reward for a service in the Procedure List, you must complete *all* the following three steps using Cost Estimator.

(a) Read the helpful information we provide about the Covered procedure or service you need so you know your options, potential complications and how to prepare for recovery.

(b) Locate a Fair Market Price Facility for the service you need.

(c) Obtain the needed service at a Fair Market Price Facility.

If you follow steps (a) and (b) but receive care for a needed procedure on the Procedure List in a facility *not* designated as a Fair Market Price Facility, you will *not* earn the reward designated for that service. Instead, you will earn a $10.00 educational award.

3. EXCLUSIONS

The following Covered Services are not eligible for cash reward under the **Priority**Rewards program described in this amendment:

- Services not included in the Procedure List.
- Services Covered as a preventive health care service.
- Services that are received during a Medical Emergency or Urgent Care visit.
- If your Priority Health Coverage is secondary to other coverage under the Coordination of Benefits provisions, the **Priority**Rewards program will not apply to you, even to services listed in the Procedure List.
- If you are Covered under a Priority Health plan through your Employer and your Employer has opted out of the **Priority**Rewards program, this amendment will *not* apply to you, even to services listed in the Procedure List.

4. PROCEDURE LIST

Procedures	Type	Reward
Colonoscopy (with and without biopsy)	Diagnostic	$100.00
Upper GI Endoscopy (with and without biopsy)	Diagnostic	$100.00
Sleep Study (conducted in a sleep center)	Diagnostic	$100.00
Most CTs	Imaging	$ 50.00
Most MRIs	Imaging	$100.00
Doppler Exam Of The Heart	Cardiac	$100.00
Heart Echo Imaging	Cardiac	$100.00
Heart Perfusion Imaging	Cardiac	$100.00
Nose Plastic Surgery (Rhinoplasty)	Outpatient	$100.00
Nasal Septum Repair	Outpatient	$200.00
Remove Tonsils & Adenoids	Outpatient	$200.00
Ear Tubes	Outpatient	$200.00
Cataract Surgery	Outpatient	$200.00
Laparoscopic Cholecystectomy	Outpatient	$200.00
Lithotripsy	Outpatient	$200.00
Knee Arthroscopy	Outpatient	$200.00
Shoulder Arthroscopy	Outpatient	$200.00
Cystocsopy	Diagnostic	$200.00
Cesarean Section Delivery	Women's Health	$200.00
Vaginal Delivery	Women's Health	$200.00
Hysteroscopy	Women's Health	$200.00
Breast Biopsy	Women's Health	$200.00
Laparoscopy, Excise Lesions	Women's Health	$200.00
Total Hysterectomy	Women's Health	$200.00
Carpal Tunnel Surgery	Bone and Joint	$100.00
Anterior Cruciate Ligament Knee Surgery (ACL)	Bone and Joint	$200.00
Total Knee Replacement	Inpatient - Bone and Joint	$200.00
Total Hip Replacement	Inpatient - Bone and Joint	$200.00
Arthroscopic Rotator Cuff Repair	Bone and Joint	$200.00

This Procedure List may be updated or changed at any time. Please visit *priorityhealth.com* or call our Customer Service department at 800 446-5674 for the most current Procedure List that applies to you during your current Contract Year.

5. MISCELLANEOUS PROVISIONS

Nothing contained in this amendment varies, alters, waives, or extends any of the terms, conditions, provisions, or limitations of your Certificate, Policy or Agreement other than as stated above.

Filed in Michigan: 2021

Doc–2021–5189

PriorityHealth®

HMO – SPONSORED DEPENDENT

The following is a summary of the benefits provided by the Sponsored Dependent rider which has been made a part of the Agreement between group and us.

The following provision is subject to all of the terms and conditions in the Certificate as well as the terms and conditions set forth in this summary.

1. ELIGIBILITY

The Covered Dependent's eligibility provision in Section 2 Eligibility subsection B of your Certificate has been changed to add the following requirements for sponsored dependents:

(4) Sponsored Dependents.

To be enrolled as a Sponsored Dependent, a person must meet each of the following requirements:

a. The person must reside with the Subscriber.

b. The person must:

- Be the Subscriber's or Subscriber's spouse's parent, or
- Be otherwise related to the Subscriber by blood or marriage as defined by the Internal Revenue Code, or
- Have the subscriber or subscriber's spouse as a court-appointed guardian, or
- Have the subscriber or subscriber's spouse as a foster parent; and

c. The person must not be eligible for Medicaid.

The Subscriber must give us proof of the person's eligibility as a sponsored dependent within 31 days after the first time we ask for it. After that, the Subscriber has to give us proof when we ask for it from time to time, but not more often than once each year.

We will not continue Coverage for a Sponsored Dependent after any one of the following happens:

a. Coverage terminates as described in Section 10 of the Certificate;

b. The Sponsored Dependent stops meeting the eligibility requirements described above; or

c. 31 days pass from the date we ask for proof of Sponsored Dependent status, if we do not receive that proof by then.

2. MISCELLANEOUS PROVISIONS

This rider supersedes any amendment or rider providing Coverage for Dependents previously issued by us. If there is any conflict between the provisions of this rider and the Certificate, the provisions of this rider will prevail. All other terms and conditions of the Certificate will remain in full force and effect.

Nothing contained in this rider varies, alters, waives, or extends any of the terms, conditions, provisions, or limitations of the Certificate other than as stated above.

Filed in Michigan: 2022

Doc_2022-2233

HMO – SKILLED NURSING SERVICES (730 DAYS PER LIFETIME)

The **Non-Hospital Facility** category on your Schedule of Copayments and Deductibles of your Certificate has been amended as follows:

Services	Benefits
Non-Hospital Facility Services - Including skilled nursing services in a: • Skilled Nursing Facility • Subacute Facility • Inpatient Rehabilitation Facility • Hospice Facility	• 100% Coverage up to the benefit maximum of 730 days per Lifetime • The Out-of-Pocket Limit applies to these services • Prior Authorization required

This rider supersedes any amendment or rider providing Coverage for non-hospital facility/skilled nursing services previously issued by us. If there is any conflict between the provisions of this rider and the Certificate, the provisions of this rider will prevail. All other terms and conditions of the Certificate will remain in full force and effect.

Nothing contained in this rider varies, alters, waives, or extends any of the terms, conditions, provisions, or limitations of the Certificate other than as stated above.

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Doc_2022-2234

If this information is unclear, or if you do not understand it, please call Priority Health for assistance at 800.446.5674 (For TDD service, please call 616.464.8485). The term "Priority Health" refers to two corporations: "Priority Health" (a Michigan nonprofit corporation) and "Priority Health Managed Benefits, Inc." (a Michigan business corporation). Priority Health is a registered trademark and is used by permission of the owner. Priority Health is an Equal Opportunity Employer.


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