

# Benefit Summary

## PriorityPPO Premier

### OPTECH

9/1/2008 - 8/31/2009

100% Network - 70% Non-Network

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

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

#### **PRIOR APPROVAL**

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

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

#### **DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS**

##### **A. Deductibles:**

The Deductible is the amount of Covered Services you must incur during the Contract Year before benefits will be paid.

The Network Benefits Deductible is applicable to all Covered Services except:

- Services with flat dollar copayments.
- Preventive health services, services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness or disability.

The Non-Network Benefit Deductible is applicable to all Covered Services, except for flat dollar copayments, received under the Non-Network Benefit level or received from Non-Network providers.

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

The Deductible renews each Contract Year. Any Deductible amount paid under the Network Benefits during the ninety (90) days preceding the start of a new Contract Year will carry over into the new Contract Year. Deductible amounts paid under the Non-Network Benefits do not carry over into a new Contract Year. The Family Deductible is not to exceed the Individual Deductible per person.

Deductibles	Network Benefits	Non-Network Benefits
Individual Contract	No Deductible	No Deductible
Family Contract	No Deductible	No Deductible

**B. Out-of-Pocket Maximums:**

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

Out-of-Pocket Maximums	Network Benefits	Non-Network Benefits
Individual	Not Applicable	\$2,500
Family	Not Applicable	\$5,000

The Network Benefits Out-of-Pocket Maximums do not apply to the Non-Network Benefits Out-of-Pocket Maximums, nor do the Non-Network Benefits Out-of-Pocket Maximums apply to the Network Benefits Out-of-Pocket Maximums.

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

- Any flat dollar Copayments, such as Copayments for office visits, ambulance and emergency services.
- Penalties
- Deductibles
- Mental health and substance abuse services
- Durable medical equipment
- Prosthetic and orthotic/support devices
- Orthognathic surgery
- Temporomandibular joint dysfunction or syndrome
- Port wine stains
- Certain surgeries

After meeting the Out-of-Pocket Maximums, the Coinsurance for these services still applies.

**Note:**

- Coinsurance made for any Covered Services obtained under a supplemental benefit Addendum may not be applied toward the above Out-of-Pocket Maximum. If your plan has a Deductible, the Deductible amounts you pay will not apply toward the Out-of-Pocket Maximum.
- If the Network or Non-Network Benefits Individual Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Reasonable and Customary Charges for covered services that apply toward out-of-pocket maximums as incurred by that person for the rest of the Contract Year. If the Non-Network Benefits Family Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Reasonable and Customary Charges for covered inpatient hospital expenses incurred by you and all your covered dependents for the rest of the Contract Year.
- If the non-notification penalty applies, the amount Priority Health pays will be reduced even if the Out-of-Pocket Maximum has been reached.

**C. Maximum Individual Lifetime Benefit:**

\$5,000,000 is the combined lifetime benefit per insured for all Network and Non-Network covered services. (Any reduction in benefits/penalty will apply to the maximum individual lifetime benefit.)

## Covered Benefits

Benefits	Network Benefits	Non-Network Benefits
<b>Preventive Health Services</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Office visit Copayment may apply</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>PHYSICIAN SERVICES</b>		
<b>Office and Home Visits</b> (evaluation and management services only)	<ul style="list-style-type: none"> <li>• \$15 Copayment</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Inpatient Hospital Visits</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Surgery</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Ambulatory Surgery Center Services</b>	<ul style="list-style-type: none"> <li>• 100% Coverage for physician surgical charges.</li> <li>• \$15 Copayment per visit for physician office services</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Obstetrical Services</b> (Prenatal delivery and postnatal evaluation and management services only)	<ul style="list-style-type: none"> <li>• \$15 Copayment per visit up to a maximum copayment of \$60 per pregnancy for routine prenatal and postnatal services only.</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>

Benefits	Network Benefits	Non-Network Benefits
<b>Vasectomy</b>	<ul style="list-style-type: none"> <li>• 100% Coverage for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery</li> <li>• 100% Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage for Physician services when performed in a physician's office or when in connection with other Covered inpatient or outpatient surgery</li> <li>• 70% Coverage for outpatient and inpatient facility charges only when in connection with other Covered inpatient and outpatient surgery</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Tubal Ligation</b>	<ul style="list-style-type: none"> <li>• 100% Coverage for Physician services</li> <li>• 100% Coverage for outpatient facility charges</li> <li>• 100% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage for Physician services</li> <li>• 70% Coverage for outpatient facility charges</li> <li>• 70% Coverage for inpatient facility charges only when in connection with delivery or other Covered inpatient surgery</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Consultations, pre-operative and post-operative visits</b> (Evaluation and management services only)	<ul style="list-style-type: none"> <li>• \$15 Copayment may apply</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Allergy Testing</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Allergy Injections</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>

Benefits	Network Benefits	Non-Network Benefits
<b>Family Planning</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Infertility Services</b> (Covered for diagnosis and treatment of underlying cause only)	<ul style="list-style-type: none"> <li>• 100% Coverage</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Temporomandibular Joint Dysfunction or Syndrome</b>	<ul style="list-style-type: none"> <li>• 50% Coverage</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>
<b>Orthognathic Surgery</b>	<ul style="list-style-type: none"> <li>• 50% Coverage</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>
<b>Certain Surgeries and Treatments (Physician fees only)</b> Reconstructive surgery: blepharoplasty of upper lids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty and surgical treatment of male gynecomastia <b>Skin Disorder Treatments:</b> Scar revision, 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*	<ul style="list-style-type: none"> <li>• Physician fees are Covered at 50%, of the first \$2,000 for each certain surgery or treatment, 100% thereafter.</li> <li>• Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>	<ul style="list-style-type: none"> <li>• Physician fees are Covered at 50%, of the first \$2,000 of Reasonable and Customary Charges for each certain surgery or treatment, 100% thereafter.</li> <li>• Prior approval required for blepharoplasty, breast reduction, panniculectomy, rhinoplasty and sleep apnea treatment. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>
<b>Treatment of Morbid Obesity</b> <ul style="list-style-type: none"> <li>• Weight loss programs</li> <li>• Bariatric surgery - limit one per lifetime</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment of morbid obesity is Covered at 50% of the first \$2,000, 100% thereafter to lifetime maximum benefit of \$25,000</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment of morbid obesity is Covered at 50% of the first \$2,000 of Reasonable and Customary Charges, 100% thereafter to lifetime maximum benefit of \$25,000</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>

Benefits	Network Benefits	Non-Network Benefits
<b>HOSPITAL SERVICES</b> (Including radiology examinations and laboratory services)		
<b>Inpatient Hospital and Long-Term Acute Care Services</b> (Including observation care, transplants and maternity stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section)	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> <li>• Notification required for admissions following emergency room care</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> <li>• Notification required for admissions following emergency room care</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Outpatient Hospital Services</b> (Including ambulatory surgery center facility charges)	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Some services may require prior approval</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Some services may require prior approval</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Medical Emergency and Urgent Care Services</b>		
<b>Emergency Room Services</b>	<ul style="list-style-type: none"> <li>• \$50 Copayment per visit. (Copayment waived only if you become confined in a Hospital.) Emergency Room physician, ancillary and special services are Covered in full.</li> </ul>	<ul style="list-style-type: none"> <li>• \$50 Copayment per visit. (Copayment waived only if you become confined in a Hospital).</li> </ul>
<b>Urgent Care Facility Services</b>	<ul style="list-style-type: none"> <li>• \$35 Copayment per visit (Copayment applies to all Urgent Care visits)</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Ambulance Services</b>	<ul style="list-style-type: none"> <li>• \$50 Copayment</li> </ul>	<ul style="list-style-type: none"> <li>• \$50 Copayment</li> </ul>
<b>Mental Health and Substance Abuse</b> (Short-term therapy and crisis intervention) Prior approval by our Behavioral Health Department is required as noted. Call 616 464-8500 or 800 673-8043		
<b>Mental Health Inpatient</b> (including partial hospitalization)	<ul style="list-style-type: none"> <li>• 100% Coverage up to 20 days per Contract Year*</li> <li>• (Two partial hospitalization days count as one inpatient day)</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges up to 20 days per Contract Year*</li> <li>• (Two partial hospitalization days count as one inpatient day)</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>

Benefits	Network Benefits	Non-Network Benefits
<b>Mental Health Outpatient</b>	<ul style="list-style-type: none"> <li>• \$20 Copayment per visit up to 20 visits per Contract Year*(\$10 Copayment per group therapy visit - two group therapy visits count as one outpatient visit)</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges per visit up to 20 visits per Contract Year* (Two group therapy visits count as one outpatient visit)</li> </ul>
<b>Substance Abuse Care Inpatient</b>	<ul style="list-style-type: none"> <li>• 100% Coverage up to the combined minimum annual benefit as determined by the State of Michigan per contract year**</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges up to the combined minimum annual benefit as determined by the State of Michigan per contract year**</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>
<b>Substance Abuse Care Outpatient</b>	<ul style="list-style-type: none"> <li>• 100% Coverage up to the combined minimum annual benefit as determined by the State of Michigan per contract year**</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges up to the combined minimum annual benefit as determined by the State of Michigan per contract year**</li> </ul>
<b>Radiology Examinations and Laboratory Procedures</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• High-tech imaging services require prior approval. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• High-tech imaging services require prior approval. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>OTHER SERVICES</b>		
<b>Prosthetic and Orthotics/Support Devices</b>	<ul style="list-style-type: none"> <li>• 50% Coverage</li> <li>• Prior approval required for devices over \$1,000</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges</li> <li>• Prior approval required for devices over \$1,000</li> </ul>
<b>Durable Medical Equipment</b> (Rent, purchase or repair)	<ul style="list-style-type: none"> <li>• 50% Coverage</li> <li>• Prior approval required for devices over \$1,000</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage</li> <li>• Prior approval required for devices over \$1,000</li> </ul>

Benefits	Network Benefits	Non-Network Benefits
<b>Facility Services</b> (Non-hospital) <ul style="list-style-type: none"> <li>• Skilled Nursing</li> <li>• Subacute</li> <li>• Inpatient Rehabilitation</li> <li>• Hospice</li> </ul>	<ul style="list-style-type: none"> <li>• 100% Coverage up to the benefit maximum of 45 days per Contract Year*</li> <li>• Prior approval required, except for Hospice. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges up to the benefit maximum of 45 days per Contract Year*</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Home Health Care</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> </ul>	<ul style="list-style-type: none"> <li>• 70% Coverage of Reasonable and Customary Charges</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250 reduction in benefits.</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Physical and Occupational Therapy</b> <b>(includes Spinal Manipulation)</b> *Combined benefit for all therapies listed.	<ul style="list-style-type: none"> <li>• \$15 Copayment per visit up to 30 visits per Contract Year.*</li> <li>• Deductible does not apply</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges up to the benefit maximum of 30 visits per Contract Year*</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Speech Therapy</b>	<ul style="list-style-type: none"> <li>• \$15 Copayment per visit up to 30 visits per Contract Year.</li> <li>• Deductible does not apply</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges up to the benefit maximum of 30 visits per Contract Year</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>
<b>Cardiac Rehabilitation and Pulmonary Rehabilitation</b> *Combined benefit for all therapies listed.	<ul style="list-style-type: none"> <li>• \$15 Copayment per visit up to 30 visits per Contract Year.*</li> <li>• Deductible does not apply</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges up to the benefit maximum of 30 visits per Contract Year*</li> <li>• Amounts paid after deductible do apply toward out-of-pocket maximums</li> </ul>

Benefits	Network Benefits	Non-Network Benefits
<b>Additional Benefits</b>		
<b>Prescription Drugs</b>	<ul style="list-style-type: none"> <li>Covered with a \$10 Generic / \$40 Brand Copayment per prescription. Includes prescription contraceptive drugs and implantable contraceptive drugs. Contraceptive devices administered or supplied in the physician's office are covered at 50%. Does Not Cover condoms, foams, jellies and ointments and other drugs or devices available over the counter. Infertility drugs covered with a 50% Copayment. (Limitations apply). No Rx Deductible.</li> </ul>	<ul style="list-style-type: none"> <li>Not Covered</li> </ul>
<b>Prescription Mail Order</b>	<ul style="list-style-type: none"> <li>Prescription drugs filled for up to 90 days with a \$20 Generic / \$80 Brand Copayment per prescription. No Rx Deductible (Limitations apply)</li> </ul>	<ul style="list-style-type: none"> <li>Not Covered</li> </ul>
<b>Eligibility Information</b>		
<b>Dependent Children</b>	<ul style="list-style-type: none"> <li>Covered until the end of the year in which dependent turns age 19. Additionally, covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or reaches the age of 25.</li> </ul>	<ul style="list-style-type: none"> <li>Covered until the end of the year in which dependent turns age 19. Additionally, covered between the ages of 19 and 25 if dependent is a full-time student, until dependent is no longer a full-time student or reaches the age of 25.</li> </ul>
<b>Early Retiree Coverage</b>	<ul style="list-style-type: none"> <li>May be available</li> </ul>	<ul style="list-style-type: none"> <li>May be available</li> </ul>
<b>65+ Retiree Coverage</b>	<ul style="list-style-type: none"> <li>May be available</li> </ul>	<ul style="list-style-type: none"> <li>May be available</li> </ul>
<b>Sponsored Dependent</b>	<ul style="list-style-type: none"> <li>May be available</li> </ul>	<ul style="list-style-type: none"> <li>May be available</li> </ul>
<b>Domestic Partner (Same Gender)</b>	<ul style="list-style-type: none"> <li>May be available</li> </ul>	<ul style="list-style-type: none"> <li>May be available</li> </ul>
<b>Domestic Partner (Same or Opposite Gender)</b>	<ul style="list-style-type: none"> <li>May be available</li> </ul>	<ul style="list-style-type: none"> <li>May be available</li> </ul>
<b>Surviving Spouse</b>	<ul style="list-style-type: none"> <li>May be available</li> </ul>	<ul style="list-style-type: none"> <li>May be available</li> </ul>
<b>Surviving Spouse and Dependents</b>	<ul style="list-style-type: none"> <li>May be available</li> </ul>	<ul style="list-style-type: none"> <li>May be available</li> </ul>

## **MAXIMUM LIMITATIONS**

### **A. Benefit Maximums:**

\* **Benefit Maximums:** Benefit maximums up to a certain number of days/visits/dollar amounts per Contract Year are reached by combining either Network or Non-Network Benefits up to the limit for one or the other, but not both. (Example: If Network Benefits is for 60 visits and Non-Network Benefits is for 60 visits, the maximum benefit is 60 visits, not 120.) The Family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person. Benefit maximums apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum. The Family Out-of-Pocket is not to exceed the Individual Out-of-Pocket maximum per person.

\*\* **Substance Abuse:** Network and Non-Network inpatient and outpatient Coverage is provided up to a combined minimum annual benefit as determined by the State of Michigan per Contract Year. Coverage amount to be adjusted each March 31<sup>st</sup> in

accordance with the average percentage increase in the "Consumer Price Index for All Urban Consumer-Revised" (CCPI).  
Coverage amount may be adjusted by an attached Addendum.