PriorityHealth

Benefit Summary

PriorityHSA^{SM} - PPO
Crawford AuSable Schools
July 1, 2011 - June 30, 2012
100% Network Benefit — 80% Non-Network

The PriorityHSA^{SM}- 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 PriorityHSA^{SM}- 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 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.

DEDUCTIBLES 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 received under the Network Benefit level except:

- Routine obstetrical services (deductible will apply to delivery).
- **Preventive health services that are listed in Priority Health's Preventive Health Care Guidelines.**

The Non-Network Benefits Deductible is applicable to all Covered Services received under the Non-Network Benefit level or received from Non-Network providers.

The Network and Non-Network Benefits Deductibles are calculated separately.

If you are the only individual on your contract, you have an Individual Contract and the Individual Contract Deductibles apply. If you have more than one individual on your contract, you have a Family Contract and only the Family Contract Deductibles apply. The Family Contract Deductibles can be satisfied by any one family member or by any combination of family members.

The Network and Non-Network Benefits Deductibles renew each Contract Year. This plan does not carry over any Deductible amounts incurred in the prior Contract Year.

The Network Benefits Deductible will include any monies paid for Covered Pharmacy Services.

Notwithstanding the above, the following costs are not credited towards any of the Deductibles: costs for services that exceed the annual day or dollar benefit maximum for a specific benefit (denied as non-Covered Services); penalties for failure to preauthorize services; or, any amounts paid by member for Non-Network Benefits that exceed Reasonable and Customary.

Deductibles	Network Benefit – 100% Plan	Non-Network Benefit – [illegible] Plan
Individual Contract	$1,200	$3,000
Family Contract	$2,400	$6,000

B. Out-of-Pocket Maximums:

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.

Once the Network Benefits Out-of-Pocket maximum is met, all further Covered medical and pharmacy services incurred at the Network Benefits level will be paid at **100% of Priority Health's contracted rate for the remainder of the Contract Year.**

Once the Non-Network Benefits Out-of-Pocket maximum is met, all further Covered medical services incurred at the Non-Network Benefits level will be paid at 100% of the lesser of billed charges or Reasonable and Customary charges for the remainder of the Contract Year.

If you have an Individual Contract, all Copayments, Coinsurance and Deductibles you paid towards Covered Services during the Contract Year will be included when calculating your Out-of-Pocket maximums. If you have a Family Contract, all Copayments, Coinsurance and Deductibles you and/or your covered family members paid collectively towards Covered Services during the Contract Year will be included when calculating your Out-of-Pocket maximums.

Notwithstanding the above, the following costs are not credited towards the Out-of-Pocket maximums: costs for services that exceed the annual day or dollar benefit maximum for a specific benefit (denied as non-Covered Services); penalties for failure to preauthorize services; or, any amounts paid by member for Non-Network Benefits that exceed Reasonable and Customary.

Note that if the non-notification penalty applies, the amount Priority Health pays will be reduced regardless of whether the Out-of-Pocket maximum has been reached.

Out-of-Pocket Maximums	Network Benefit – 100% Plan	Non-Network Benefit – [illegible] Plan
Individual Contract	$2,000	$4,000
Family Contract	$4,000	$8,000

The amounts calculated towards the Non-Network benefits Out-of-Pocket Maximums also apply to the amounts calculated towards the Network Benefits Out-of-Pocket Maximums. The Network Benefits Out-of-Pocket Maximums do not apply to the Non-Network Benefits Out-of-Pocket Maximums.

C. Maximum Annual Benefit:

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