HealthPlus of Michigan

http://www.healthplus.org

Customer service 1-800-332-9161

2016

A Health Maintenance Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. Enrollment in this plan is limited. You must live or work in our geographic service area to enroll.

See page 7 for requirements

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 13
- Summary of benefits: Page 79

Serving: Eastern Michigan

Enrollment codes for this Plan:
X51 Self Only

X53 Self Plus One

X52 Self and Family

This plan has excellent accreditation from the NCQA. See the 2015 guide for more information on accreditation.

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-648

Important Notice from HealthPlus of Michigan About

Our Prescription Drug Coverage and Medicare

The Office of Personal Management (OPM) has determined that the HealthPlus of Michigan plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and HealthPlus of Michigan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefit

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this plan is available through the Social Security Administration (SSA) online at www.socialsecurity.gov , or call the SSA at 1-800-772-1213 (TTY: 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048).

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Introduction

This brochure describes the benefits of HealthPlus of Michigan under our contract (CS 2712) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at (800) 332-9161 or through our website: www.healthplus.org. The address for HealthPlus of Michigan administrative offices is:

HealthPlus of Michigan, Inc.
2050 South Linden Road
P.O. Box 1700
Flint, MI 48501-1700

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a mininum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means HealthPlus of Michigan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statement that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at (800) 332-9161 and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise);
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received . You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use HealthPlus preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  - See www.opm.gov/healthcare-insurance for enrollment information as well as:
  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment;
  - How you can cover your family members;
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
  - When happens when your enrollment ends;
  - When the next Open Season for enrollment begins.

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of any changes to family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family member is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouses or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll Self Plus One or for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2016 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2015 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

  If you are divorced from a Federal employee, Tribal employee, or an annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at http://www.opm.gov./healthcare-insurance/healthcare/plan-information/.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

  You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Finding replacement coverage**

  In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 800-332-9161 or visit our website at www.healthplus.org.

- **Health Insurance Marketplace**

  If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace please visit www.HealthCare.gov. This is a web-site provided by the U.S. Department of Health and Human Services that provides up to date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Who provides my healthcare?

Each family member that is covered by HealthPlus must choose a primary care physician from the Provider Directory (parents are expected to select for their children). This list includes hundreds of doctors who specialize in Family Practice, Internal Medicine, or Pediatrics. The listing for each primary care physician also shows a "primary hospital." This is the hospital where your primary care physician will direct you for hospital services in most instances. When you select a primary care physician, you also are agreeing to use the hospital listed.

The primary care physician you choose will coordinate your overall medical care, including arranging for hospital admissions or care by a specialist when medically necessary. Most specialty services require a referral other than an annual well-woman exam with a participating gynecologist or routine obstetrical services with a participating obstetrician.

HealthPlus strives to keep the Provider Directory as up-to-date as possible. However, information may change after the Directory has been printed. If the physician you select is no longer accepting patients, please select another. You may want to call the physician you have chosen prior to calling the HealthPlus Customer Service Department at (800) 332-9161 with your selection. You must notify HealthPlus before receiving covered services from the new Primary Care Physician.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, our providers, and our facilities. OPM's FEHB website (www.opm.gov/healthcare/insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- HealthPlus service area
- HealthPlus Federal brochure
  - Covered benefits, including prescription drug coverage
  - Description of emergency health coverages and benefits
  - Out-of-area coverage and benefits
  - An explanation for copayments and any other out-of-pocket expense
- Continuity of treatment
  - Arrange for the continuation of treatment by that provider; or
  - Assist the member in selecting a new provider
- Additional information

- Provider information
- Physician credentials
- Physician status/discipline
- Specific benefits
- Financial arrangement with physicians
- Who to contact

• Years in existence

• Profit status

If you want more information about us, call (800) 332-9161, or write to our Customer Service Department at: 2050 South Linden Road, P.O. Box 1700, Flint, MI 48501-1700. You may also contact us by fax at 810-496-8440 or visit our website at www.healthplus.org.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live or work in our service area.

Our service area includes Arenac, Bay, Genesee, Huron, Iosco, Lapeer, Livingston, Macomb, Oakland, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw and Wayne Counties in Michigan, with exceptions as outlined below:

The following areas are not included in the HealthPlus service area: SANILAC COUNTY: Bridgehampton Township, Buel Township, Croswell Township, Custer Township, Elk Township, Forester Township, Fremont Township, Greenleaf Township, Lexington Township, Marion Township, Sanilac Township, Speaker Township, Washington Township, Wheatland Township and Worth Township.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. Eligible college students are covered for emergency illnesses or injuries that occur when they are out of the service area. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2016

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Self Plus One enrollment type has been added effective January 1, 2016.
- We have removed the exclusion for services,drugs, or supplies related to sex transformations. See page 55.

Changes to this Plan

- Primary care office visit copayment, you now pay $20. See page 23.
- Specialist office visit copayment, you now pay $40. See page 23.
- Infertility services are covered for diagnosis and treatment of the underlying cause of infertility **only.** All assisted reproduction methods and fertility drugs are excluded. Applicable office visit copayment applies. See page 26.
- Applied Behavior Analysis (ABA), therapies and outpatient services, you now pay a $20 copayment per visit. See page 27.
- Physical and occupational therapies are now covered for 60 combined visits per benefit year with a $20 copayment. See page 28.
- Speech therapy is now covered for 30 visits per condition with a $20 copayment. See page 29.
- Home health services are now covered for 60 skilled nursing visits per benefit year with no copay. See page 30.
- Inpatient hospital, you now pay a copayment of $500 per admission. See page 40.
- Emergency room copayment, you now pay $200 per visit. See page 44.
- Urgent care copayment, you now pay $40 per visit. See page 44.
- The Plan now has a closed drug formulary. Drugs that are listed on the formulary are covered; drugs that are not listed on the formulary are not covered. See page 47.
- The prescription drug benefit will be as follows:

  Retail pharmacy (up to a 30 day supply):

  - Tier 1 $20 per generic drug
  - Tier 2 $40 per preferred formulary brand drug
  - Tier 3 $80 per non-preferred formulary drug brand. This copayment also applies when an exception request is approved for a non-formulary drug.
  - Tier 4 $25% coinsurance up to $250 maximum per fill for formulary specialty medications

  Mail order or retail (90 day supply):

  - Tier 1 $50 per generic drug
  - Tier 2 $100 per preferred formulary brand drug
  - Tier 3 $200 per non-preferred formulary drug brand. This copayment also applies when an exception request is approved for a non-formulary drug.
  - Tier 4 (mail order not applicable for this tier)
- The Plan has eliminated $0 copayment for selected generic preventive drugs (90 day supply). See page 49.
- Online convenience care (virtuwell™, an online clinic) is available with no copayment. See page 23.
- The Plan has eliminated coverage for an additional eye exam to determine the need for vision correction for children through age 17, beyond initial preventive exam. See page 29.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 332-9161 or write to us at P.O. Box 1700, Flint, MI 48501-1700. You may also request replacement cards through our website at www.healthplus.org.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. Participating providers strive to provide quality health care consistent with recognized medical standards, HealthPlus policy, and your subscriber benefits. Health care services must be obtained through, or under the direction of, your primary care physician. He or she will coordinate your health care and, when medically necessary, refer you to a specialist from our network of health care providers. Your role is to always work with your primary care physician for your health care needs. The selection of your primary care physician is the key to obtaining the benefits available to you.

Refer to the Provider Directory located on the HealthPlus website. The HealthPlus Provider Directory is a convenient reference that lists independent primary physicians, specialist physicians, and other health care providers who have agreed to provide services to HealthPlus members. This directory will assist you in the selection of a primary care physician for you and each member of your family.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Each family member that is covered by us must choose a primary care physician from the Provider Directory (parents are expected to select for their children). This list includes doctors who specialize in Family Practice, Internal Medicine, or Pediatrics. The listing for each primary care physician also shows a "primary hospital." This is the hospital where your primary care physician will direct you for hospital services in most instances. When you select a primary care physician you are also agreeing to use the hospital listed. The primary care physician you choose will coordinate your overall medical care, including arranging for hospital admissions or care by a specialist when medically necessary. HealthPlus strives to keep the Provider Directory as up-to-date as possible. However, information may change after the Directory has been printed. If the physician you select is no longer accepting patients, please select another. You may call our Customer Service Department at (800) 332-9161 with your selection. You must notify us before receiving covered services from the new primary care physician.

- **Primary care**

Your primary care physician can be a family practitioner, internist, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician the referral remains open for a period of 60 to 365 days without additional referrals being necessary. The open period is determined by your primary care physician. Once the time period for an open referral has expired, you will need to obtain a new referral.

Some services, such as those listed below, may be subject to other requirements or limitations which you should discuss with your physician:

- Behavioral health services
- Physical, occupational and speech therapy
- Chiropractic services
- Services rendered by non-contracted/out-of-area specialists
- Services requiring ongoing review for medical necessity

Prior authorization by a Plan Medical Director is required for out-of-plan referrals.

Female members may see a participating gynecologist or obstetrician for routine services without a referral.

You may see a participating mental health or substance abuse provider for an initial office visit without a referral, but continued coverage is dependent upon approval of the mental health or substance abuse provider's treatment plan.

Here are some other things you should know about specialty care:

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan;
  - reduce our service area and you enroll in another FEHB plan
  - You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (800) 332-9161. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out;
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other Services*.

- **Inpatient hospital admission**

Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered; medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- BRCA Mutation Testing
- Cardiology
- Compounded Medications
- Growth Hormones
- High tech radiology services performed in an outpatient setting, such MRI, CAT scan or PET scans
- Transplants

How to request precertification for an admission or get prior authorization for Other Services

First, your physician, your hospital, you, or your representative, must call us at (800) 332-9161 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days of days requested for hospital stay

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need any extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide, whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (800) 332-9161. You may also call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (800) 332-9161. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

If you, your representative, the physician or the hospital does not contact HealthPlus for precertification you may be responsible for all charges incurred when using non-network facilities.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accordance with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have **a post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 days.

   If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician, you pay a copayment of $20 per office visit, and when you see a specialist physician you pay a copayment of $40 per office visit.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We do not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care.
Your catastrophic protection out-of-pocket maximum	After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $6,350 for Self Only, or $12,700 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $6,350 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.*** Example Scenario: Your plan has a $6,350 Self Only maximum out-of-pocket limit and a $12,700 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $6,350 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $12,700, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $6,350 for the calendar year before their qualified medical expenses will begin to be covered in full. However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services: • Any expense which is not a covered service. • Services provided without the proper authorization. • Non-affiliated provider expenses without being appropriately referred. Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.
Carryover	If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill us

Facilities of the Department Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High Option Benefits

(See page 13 for how our benefits changed this year and page 79 for a benefits summary.)

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Section 5. Benefits Overview

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at (800) 332-9161 or on our website at www.healthplus.org.

The HealthPlus HMO for Federal employees provides you with the following benefit/cost advantages:

- No deductibles
- 100% coverage for preventive care
- $20 office visit copay with your PCP, $40 for specialist visits
- $20 generic/$40 formulary brand/$80 non-formulary brand prescription copay/25% coinsurance up to a maximum $250 per specialty prescription

Here are some other great features:

- ***Customer service you can count on.*** Almost three decades of serving mid-Michigan. It adds up to the experience and commitment to provide you with the highest quality care. When you call our Customer Service Department, you'll speak with a real person who is dedicated to providing you with a quick response to your questions and concerns.
- ***Save on prescriptions with "Ask for 90 Rx".*** Pay less on your prescription copays when you pay once to fill a 90-day prescription at a participating pharmacy vs. filling the same prescription three times in three months.

For benefit details, pricing, and further information, please contact HealthPlus Customer Service at: (800) 332-9161, (TDD 1-800-992-5070), or visit our web site at www.healthplus.org/federal.aspx.

Walk-In Customer Service available weekdays, 8 a.m. - 5 p.m. at:

FLINT 2050 S. Linden Rd., Flint, MI 48532

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Prior authorization is required for certain services.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • Office medical consultations • At home • Second surgical opinion	$20 per office visit with your PCP $40 per office visit with a specialist
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing
Urgent care	$40 per office visit
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Benefit Description	You pay
Preventive care, adult	**High Option**
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Well woman care including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus Contraceptive coverage for women of reproductive capacity including: • Female sterilization procedures • Injectable contraceptives and insertion/removal of contraceptive devices • Generic prescription oral contraceptives (with a prescription from physician) • Brand name prescription oral contraceptives if the Member cannot tolerate a generic • Contraceptive counseling as part of the annual well woman exam or part of annual routine maintenance exam. Screening and counseling for interpersonal and domestic violence	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • Baseline by the age of 40 • From age 40 through 49, one mammogram every one or two years • At age 50, one yearly	Nothing
Breast and Ovarian Cancer Susceptibility: • Genetic Risk Assessment • BRCA Mutation Testing and counseling (one test per lifetime; see prior authorization)	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Note: A complete list of preventive care services recommended under the U.S. Preventive Service Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations and https://www.healthcare.gov/preventive-care-benefits/	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel* • *Examinations, reports or any other services related to requirements or documentation or health status for employment, licenses, insurance, travel, or for educational or sports/recreational purposes*	*All charges*
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Service Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations andhttps://www.healthcare.gov/preventive-care-benefits/	
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at high risk. • Delivery • Postnatal care	Nothing
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind:	

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
• You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (see *Surgical procedures Section 5 (b)*) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Medically-indicated genetic testing and counseling per generally accepted medical practice Note: We cover oral contraceptives under the prescription drug benefit.	Nothing
Not covered: • *Reversal of voluntary sterilization and all associated cost* • *Premarital exams or classes*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of the underlying cause of infertility only. All assisted reproductive methods and fertility drugs are excluded.	$20 per office visit with your PCP $40 per office visit with a specialist
Not covered: *Assisted reproductive technology (ART) procedures, such as:* • *Artificial insemination* • *Intravaginal insemination (IVI* • *Intracervical insemination (ICI)* • *Intrauterine insemination (IUI))* • *In vitro fertilization*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
• *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Reversal of a voluntary sterilization and all associated costs* • *Pre-embryo cryo preservation techniques and associated services* • *Infertility services if one of the partners has previously undergone surgical sterilization or if one of the partners is menopausal or post menopausal* • *All services related to a surrogate parenting arrangements of any kind* • *Cost of donor sperm and all associated costs* • *Cost of donor egg* • *Fertility drugs*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	$20 per office visit with your PCP $40 per office visit with a specialist
Allergy Serum	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 37. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. Your primary care physician calls us for a referral. We will ask your physician to submit information that establishes that the GHT is medically necessary. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *You need prior Plan approval for certain services* in Section 3.	Nothing
Applied Behavior Analysis (ABA) for Children	Therapies: $20 copay per visit

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High Option**
• Applied behavior analysis therapy to diagnose and treat ASD • Physical, occupational and speech therapy as part of ASD • Outpatient mental health services to diagnose and treat ASD Physical therapy, speech therapy, occupational therapy provided as part of the treatment of autism spectrum disorders. A Prior Authorization is required from HPM. If these therapies do not result in measurable progress over a 6 month intervention period, Coverage for further treatment may be denied. Physical therapy, speech therapy, and/or occupational therapy serivces used as part of the autism benefit will not count toward the number of medical visits that may be limited for these therapies. Coverage for the diagnosis and treatment of the above autism spectrum disorders will be provided to a Member through 18 years of age.	Therapies: $20 copay per visit Outpatient services: $20 copay per visit
Physical and Occupational Therapies	**High Option**
60 combined visits per benefit year are covered for the following services: • Qualified physical therapists • Occupational therapists • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is covered with no visit limits	$20 copay per visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Vocational rehabilitation services*	*All charges*
Speech therapy	**High Option**
30 visits per condition	$20 copay per visit
Hearing services (testing, treatment, and supplies)	**High Option**
• Hearing aids and hearing tests for fitting and post performance evaluation Note: For routine hearing screening performed during a child's preventive care visit, see *Section 5(a) Preventive care, children.*	Nothing
Not covered: • *Hearing aids ordered prior to the effective date of coverage under this contract* • *Replacement and/or repair because of loss or misuse* • *Batteries* • *Cost above the conventional type of hearing aid when not medically necessary*	*All charges*

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	**High Option**
Initial pair of glasses after cataract surgery	Nothing
Not covered: • *Vision services that are not shown as covered.*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	$20 per office visit with your PCP $40 per office visit with a specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and Prosthetic Devices	**High Option**
Orthotic appliances and prosthetic devices (including breast prosthesis following a mastectomy) • Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • External hearing aids • Internal hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome Note: For information on the professional charges for the surgery to insert an implant, see *Section 5(b) Surgical procedures.* For information on the hospital or ambulatory surgery center benefits, see *Section 5(c) Services provided by a hospital or other facility, and ambulatory service.*	Nothing
Not covered: • *Orthotic Appliances not used to support, align, prevent, correct, or improve a defect of body form or function.* • *Comfort and convenience equipment, exercise and hygiene equipment, dental appliances, experimental or research equipment, and self-help devices not medical in nature.*	*All charges*

Benefit Description	You pay
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps	Nothing
Not covered: Equipment that is not deemed medically necessary or is an upgrade to accepted standards.	*All charges*
Home Health Services	**High Option**
The following services are covered with 60 skilled nursing visits per benefit year: • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Personal comfort or convenience items such as television and telephone services* • *Skilled nursing services provided on a twenty-four (24) hour basis in the home* • *Private duty nursing services (except if medically necessary in an inpatient setting).*	*All charges*

Benefit Description	You pay
Chiropractic	**High Option**
Spinal Manipulation when provided by, or under the direction of, your Primary Care Physician, or provided by a Specialist Physician Physician to whom you are appropriately referred.	$20 per office visit with your PCP $40 per office visit with a specialist
Not covered: • *Hypnosis* • *Biofeedback* • *Acupuncture*	*All charges*
Alternative treatments	**High Option**
No benefit	*All charges*
Educational classes and programs	**High Option**
Educational classes and programs: • Health Coaching - telephone based coaching to assist in making healthier lifestyle choices. • Online Programs - a variety of online educational wellness programs. • Community Classes - reimbursement for tobacco cessation classes.	Nothing
Not covered: Premarital exams or classes	*All charges*

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery • Surgical treatment of morbid obesity (bariatric surgery) - a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over - the Plan Medical Director may authorize bariatric surgery (Roux-en Y, vertical banded gastroplasty or laproscopic surgery) for members over age 18, when certain criteria are met and documented by the member's PCP - generally, HealthPlus requires the member to be 100 pounds or more overweight (depending on height); have at least one additional risk factor, such as heart disease, or diabetes; undergo an evaluation to rule out other causes of obesity; document compliance with a medically prescribed diet and weight loss regimen for a minimum of six (6) months; and, undergo counseling to ensure understanding of the procedure and its risks and limitations	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
• Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of condition of the foot, see Foot care*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation* • *Other services and procedures for Cosmetic purposes, such as procedures to correct baldness or wrinkling* • *Wigs, prosthetic hair, hair transplants, or other procedures or supplies to enhance hair growth*	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Orthognathic surgery prior to the age of twenty-one (21) for congenital defects directly affecting the growth, development, and function of the jaw; • Hospitalization charges for multiple extractions which must be performed in a Hospital due to a concurrent hazardous medical condition; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental care and associated supplies, services, and tests, except as specifically provided in this section.*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other Services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Lung, single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis. - Isolated Small intestines - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Marrow Failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Chronic myelogenous leukemia - Hemoglobinopathies - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Neuroblastoma - Amyloidosis • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - Denovo myeloma	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Pineoblastoma - Waldenstrom's macroglobulinemia	Nothing
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic on non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma Tandem transplants for covered transplants: Subject to medical necessity	Nothing
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patients condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Beta Thalassemia Major - Chronic Inflammatory Demyelination Polyneuropathy (CIDP) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathies - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Multiple sclerosis	Nothing
• Nonmyeloablative allogeneic transplants or Reduced intensity conditioning (RIC) for	
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
- Myelodysplasia/myelodysplastic syndromes	
- Advanced Hodgkin's lymphoma	
- Advanced non-Hodgkin's lymphoma	
- Breast cancer	
- Chronic lymphocytic leukemia	
- Chronic myelogenous leukemia	
- Colon cancer	
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)	
- Multiple myeloma	
- Multiple sclerosis	
- Myeloproliferative disorders	
- Non-small cell lung cancer	
- Ovarian cancer	
- Prostate cancer	
- Renal cell carcinoma	
- Sarcomas	
- Sickle Cell disease	
• Autologous transplants for	
- Aggressive non-Hodgkin lymphomas	
- Chronic lymphocytic leukemia	
- Chronic myelogenous leukemia	
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)	
- Multiple sclerosis	
- Systemic lupus erythematosus	
- Systemic sclerosis	
- Scleroderma-SSc (severe,progressive)	
National Transplant Program (NTP) - A case manager is assigned upon notification of a member needing a transplant. The physician, member and case manager develop a treatment plan specific to the member's medical needs.	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Medical expenses incurred by a non-Member who donates an organ or tissue to a Member will only be covered if the non-Member does not have coverage for these services.* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Freestanding emergency center • Office	Nothing

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$500 copay per admission
• Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	
Not covered: • *Custodial care or domiciliary care, basic care, or housekeeping* • *Non-covered facilities, such as nursing homes, schools* • *Services or products provided by convalescent homes, homes for the aged, or adult foster care facilities*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private duty nursing, unless medically necessary* • *Blood and blood derivatives not replaced by the Member*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note**:** We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: • *Custodial or domiciliary care, basic care, or housekeeping* • *Personal comfort or convenience items such as television and telephone services* • *Blood and blood derivatives not replaced by the member* • *Private duty nursing*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Benefits for care in a skilled nursing facility shall be limited to a maximum of one hundred (100) days per Member per benefit year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.	Nothing
Not covered: • *Custodial or domiciliary care, basic care, or housekeeping* • *Personal comfort or convenience items such as television and telephone services* • *Private duty nursing services* • *Blood and blood derivatives not replaced by the member*	*All charges*

Benefit Description	You pay
Hospice care	**High Option**
Hospice services provided by a Hospice under the direction of a Plan doctor who certifies that the member is in the terminal stages of illness, with a life expectancy of approximately six months or less. Services must be ordered by your Primary Care Physician and authorized in advance by us. Services are limited to: • Room and board charges • Medical supplies, drugs and medicines • Medical-social services	Nothing
Not covered: • *Custodial or domiciliary care, basic care* • *Independent nursing, homemaker services* • *Personal comfort or convenience items such as television and telephone services* • *Private duty nursing services* • *Skilled nursing services provided on a twenty-four (24) hour basis in the home*	*All charges*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate.	Nothing

Section 5(d). Emergency services/accidents

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area: Members are covered for treatment when a true emergency exists. If you are in doubt of the seriousness of the medical condition and have time to call your Primary Care Physician, you should do so. If your physician feels that the problem requires immediate attention, he or she will direct your treatment. Please note: Emergency health services rendered by a participating provider within our service area are covered. Also, services will be covered if they are rendered by a non-affiliated provider because an emergency prevents you from receiving services from a participating provider.

Emergencies outside our service area: In case of an emergency when you are out of the HealthPlus service area, we provide coverage for necessary care. If your problem is too serious to wait until you return to the HealthPlus service area, go to a physician, after-hours care center, or the hospital nearest you for treatment. Emergency admissions require notification to HealthPlus within 24 hours, or as soon thereafter as possible. You may call HealthPlus 24 hours a day at the Emergency Services number on the back of your HealthPlus identification card. Please call promptly after an emergency in order to confirm coverage, ensure proper follow-up care and assure payment for covered services you receive.

Note: We reserve the right not to pay for non-emergency treatment received at emergency facilities. If you are hospitalized at non-affiliated hospital, you may be transferred to an affiliated hospital upon request of your Primary Care Physician as soon as it is medically appropriate in the opinion of the attending physician. Should you, or your designee, refuse a transfer to an affiliated hospital, continued care provided to you at a non-affiliated hospital shall not constitute covered services and shall no longer be the financial responsibility of us. Follow-up visits to non-affiliated providers of emergency health services outside the service area shall be limited to two (2) Visits within thirty (30) days of the emergency, or the number of visits specified in a treatment plan approved by us.

Benefit Description	You pay
Emergency within or outside our service area	**High Option**
Emergency care at a doctors' office	$20 per visit with your PCP $40 per visit with a specialist
Emergency care at an urgent care center	$40 per visit at an urgent care center
Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$200 per visit at a hospital emergency room, waived if admitted to the hospital
Not covered: • *Elective care or non-emergency care* • *Blood and blood derivatives not replaced by the member*	*All charges*

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan: Contact HealthPlus Behavioral Service department at (800) 555-5025.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional Services	**High Option**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnostic and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Inpatient services: $500 copay per admission Outpatient services: $20 copay per visit

Benefit Description	You pay
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Inpatient services: $500 copay per admission Outpatient services: $20 copay per visit
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$500 copay per admission
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$20 copay per visit

Section 5(f). Prescription drug benefits

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- We have no calendar year deductible.
- The prescription drug benefit has a “Mandatory Generic” provision. If you elect to receive the brand, when a generic alternative is available, you will be responsible for the difference in cost between the generic and brand, in addition to the generic copay.
- Most chronic medications (medications you take every day) must be filled in a 90-day supply, either at an"Ask for 90 Rx" participating retail pharmacy or by mail order through Express Scripts.
- Most injectable medications (other than injectable medications for diabetes), and specialty oral medications, must be obtained from certain specialty pharmacies.
- All compounded medications require a prior authorization. Compounded medications may be approved for coverage if you have trouble swallowing or are sensitive to dyes, preservatives, or fillers, or for children who require prescription medications for which there are no liquid formulations available.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

These are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistants, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill prescriptions at a participating pharmacy, or through Express Scripts for mail order. Specialty medications must be filled at certain specialty pharmacies. Go to www.healthplus.org/federal.aspx to our online Provider Directory to search for a list of pharmacies by zip code or proximity. If you have questions about mail order pharmacy services, call HealthPlus at (800) 332-9161 or Express Scripts at (877) 322-8471. You may also print an Express Scripts mail order form from the website at www.healthplus.org/federal.aspx.
- **We use a formulary.** The HealthPlus Drug Formulary is a CLOSED formulary with restrictions. This means that drugs that are listed on the formulary are covered. Drugs that are not listed on the formulary, also referred to as non-formulary, are not covered. This may include drugs that are not as effective or safe, or may be higher in cost than similar drugs that are on the formulary. Some formulary medications may require step therapy, prior authorization or quantity limits. A generic mandate applies, which means that the generic drug is on the formulary when a drug is available in generic. The equivalent brand drug is in the non-preferred formulary brand tier. You have the option to receive the non-preferred brand name medication instead of the generic, but you are responsible for the difference in cost between the brand and generic drug, plus your usual copay.

  If a drug that you have been prescribed is not on the formulary, you can ask your doctor if you can switch to a similar formulary drug. You or your doctor may also request an exception to the formulary, but it must be based on medical necessity. You may request an exception by telephone or at the website, but HealthPlus will contact your doctor for more information. Your doctor must provide the medical information that is required to review the request. Go to www.healthplus.org/federal.aspx for more information about the Exception Process.

- The closed drug formulary is a **4-Tier Drug Formulary**. The first three copay tiers have a fixed copay amount and are designed to maximize the use of generic or preferred formulary brand drugs. The fourth tier is a percent copay for formulary specialty medications. This includes many injectable and oral specialty medications. Medications in the fourth copay tier must be obtained at certain specialty pharmacies.

  - Tier 1/Generic Drugs = lowest copay
  - Tier 2/Preferred Formulary Brand Drugs = medium copay
  - Tier 3/Non-Preferred Formulary Brand Drugs = higher copay
  - Tier 4/Specialty Medications = coinsurance based on the cost of the drug up to maximum copay

For more information on the HealthPlus Drug Formulary, visit our Web site at www.healthplus.org/federal.aspx or call HealthPlus Customer Service at (800) 332-9161.

- **These are the dispensing limitations.** Prescriptions written by a Plan or referral doctor will be dispensed for up to a 30-day supply. Prescriptions written by a Plan or referral doctor and obtained through the "Ask for 90 Rx" program at a participating retail pharmacy, or by mail order through Express Scripts, may be dispensed for up to a 90-day supply. Specialty medications are limited to a 30-day supply per fill and must be obtained at certain specialty pharmacies.
- **"Mandatory ASK for 90 Rx"** is a program developed by HealthPlus for chronic medications (medications you take every day), with copay savings for a 90-day supply. Please note the following items:
  - Most pharmacies participate with the "Ask for 90 Rx" program. If you need assistance finding a pharmacy, please call Customer Service at (800) 332-9161 or go to www.healthplus.org/federal.aspx for the online Provider Directory.
  - For medications in copay tiers 1, 2, and 3, you pay 2.5 usual copays for a 90-day supply instead of 3 copays.
  - Injectable diabetic medications (such as insulin), glucagon and EpiPens are available in the "Ask for 90 Rx" program.
  - Specialty injectable medications, oral specialty medications and prescription compounds are excluded from the "Ask for 90 Rx" program. Prescriptions filled for 90 days are subject to standard HealthPlus prior authorization and Step Therapy programs, and the restrictions and exclusions in this brochure.
  - For quantity-limited drugs, such as erectile dysfunction or migraine medications, the quantity limit is based on the days supply of the fill (for example, a limit of 6 in 30 days is increased to 18 in 90 days).
  - It is not medically appropriate to fill all drugs in a 90-day quantity. Your physician will determine what is best for your care.
- **Why use generic drugs?** Generic drugs cost less than the more expensive brand-name drugs. But, they must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. The U.S. Food and Drug Administration (FDA) sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. Using the most cost-effective medication makes sense and saves money. However, you and your physician have the option to request a brand-name drug even if a generic option is available. If you do, you are responsible for the difference in cost between the generic and the brand-name drug, in addition to the generic copayment.
- **When you have to file a claim.** If you receive a bill or statement, or are requesting reimbursement for an out-of-pocket area emergency, please mail the bill and the completed Request for Reimbursement Form to us within 90 days of the date of service. You may download a Request for Reimbursement Form from our website at www.healthplus.org/federal.aspx. If you need further assistance, or have questions, please call our Customer Service Department at (800) 332-9161.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan or referral physician and obtained from a Plan pharmacy: • FDA approved drugs that require a prescription by law, except as excluded below • Insulin and insulin syringes • Diabetic testing reagents and supplies, including glucose test strips, test tape, and alcohol swabs • Disposable needles and syringes for the administration of covered medications • Self administered injectable drugs and medication for home use (injectable and intravenous medications administered in the office or at a facility are covered under medical and surgical benefits) • Growth hormone (see prior authorization)	**Retail Pharmacy (up to a 30-day supply)** Tier 1 $20 per generic drug Tier 2 $40 per preferred formulary brand drug Tier 3 $80 per non-preferrred formulary brand drug. This copayment also applies when an exception request is approved for a non-formulary drug. Tier 4 25% coinsurance up to $250 maximum per fill for specialty medications **Retail Pharmacy or mail order (90-day supply)** Tier 1 $50 per generic drug Tier 2 $100 per preferred formulary brand drug Tier 3 $200 per non-preferred formulary brand drug. This copayment also applies when an exception request is approved for a non-formulary drug. Tier 4 (not available for retail or mail order for this tier)
• Women's contraceptive drugs and devices • Tobacco cessation drugs • Vitamin D and asprin for adults 65 and Older Note: Over-the-counter drugs and devices require a written prescription by an approved provider.	Nothing
• Prescription drugs for treatment of sexual dysfunction: Coverage will not exceed six (6) doses per thirty (30) day period.	50% per unit or refill
Not covered: • *Fertility drugs* • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients, food supplements and medical foods even if a physician prescribes or administers them, except as covered above* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Replacement of lost, stolen, or destroyed medication*	*All charges*

Section 5(g). Dental benefits

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing
Dental benefits	**High Option**
We have no other dental benefits.	*All charges*

Section 5(h). Special features

With HealthPlus, you can take advantage of our year-round program that offers a variety of wellness activities to help you feel great, boost energy and learn more about your health. Whether you are in good health or need a plan to get started, our wellness tools and programs can help you improve your health, reduce your risks and improve quality of life. Our HealthPlus HealthQuest Health & Wellness benefits and features include:

NCQA "Excellent" accreditation	We have been awarded "Excellent" Accreditation status for our Commercial HMO – the highest level possible by the National Committee for Quality Assurance (NCQA). NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.
High risk pregnancies	A case manager is assigned upon notification of a high risk pregnancy. The physician, member, and case manager develop a treatment plan specific to the member's medical needs.
Disease management program	If you have diabetes, asthma, lung disease, or certain heart diseases, you may be eligible to participate in our Disease Management Programs. These programs are designed to help you better understand and manage your condition, so you can enjoy improved health and quality of life. Ask your physician to refer you, or contact us at (800) 345-9956 extension 8050 for more information.
Centers of excellence for transplants/heart surgery/etc.	HealthPlus is pleased to provide the following list of Commercial HMO participating providers who are Centers of Excellence. **Organ Transplantation:** • Children's Hospital of Michigan - Detroit, Michigan • Henry Ford Hosptial - Detroit, Michigan • Karmanos Cancer Institute - Detroit, Michigan • University of Michigan Hospitals - Ann Arbor, Michigan **Comprehensive Cancer Care** - Comprehensive Cancer Center as designated by the National Cancer Institute and/or accredited facility by the American College of Surgeons for Cancer Programs: • Cleveland Clinic Foundation • Crittenton Hospital Medical Center – Rochester, MI • Covenant Healthcare – Saginaw, MI • Genesys Regional Medical Center – Flint, MI • Henry Ford Hospial – Detroit, MI • Hurley Medical Center – Flint, MI • Karmanos Cancer Institute – Detroit, MI • McLaren Health System - Flint, MI • Memorial Healthcare – Owosso, MI • Oakwood Health Care – Dearborn, MI • Port Huron Hospital – Port Huron, MI • St. Joseph Mercy - Ann Arbor, MI • St. Joseph Mercy Oakland - Pontiac, MI • St. Mary's Medical Center – Saginaw, MI • University of Michigan Hospitals - Ann Arbor, MI • William Beaumont Health System –Royal Oak, MI

	Cardiac Care - *(2015 Excellence Awards from HealthGrades in Cardiac Care):* • Henry Ford Hospital – Detroit, MI • Providence Hospital – Southfield, MI • William Beaumont Health - Troy, MI
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
College students	Eligible college students are covered for emergency illnesses or injuries that occur when they are out of the service area. Contact us at (800) 332-9161 for eligibility requirements.
Smoking Cessation and Weight Management Programs	These programs are offered in a variety of ways. We have virtual health coaching programs as well as live health coaches who communicate via phone or email. The wellness assessment will be your entry into these programs or you may enroll yourself by calling 866-810-4540.
Wellness Program—Gateway to a Healthier U™	Live healthier and earn $75 **Eligibles:** All employees and dependents 18 years and older **Step 1** **Wellness Visit**: Visit your primary care provider (PCP) for completion. Have them complete a Wellness Visit Form which the member must send to HealthPlus. During this visit, your PCP will verify that you are up to date on all preventive services including a biometric screening which includes blood pressure, body mass index (BMI), cholesterol and glucose. You will earn a $25 gift card for completing this step. **Step 2** **Wellness Assessment:** Complete an online wellness assessment about your health status. This assessment includes 40-50 questions and takes approximately 20 minutes to complete. The wellness assessment is accessed on the HealthPlus website, www.healthplus.org/healthieru. You will earn a $50 gift card for completing this step. **Deadline for completing these two steps is June 30, 2016.**

	Opportunity: Complete both steps and earn a total of a $75 gift card award ($75 per member up to $200 per family) *Note: After June 30, 2016, members may still complete both the screening and assessment; however they will not be eligible to receive rewards.*
Healthier U™	Upon completion of these steps you will be introduced to all of the HealthPlus resources and benefits available to you through Healthier U™. All of these are at no cost to you. **A personalized plan to help you improve or maintain your healthy lifestyle including:** • Personal home page based on your health risks, interests and personal health reminders. • Virtual health coaching - a self-directed online program to assist you in areas of nutrition, physical activity, weight loss or stress management. • Online Seminars - monthly seminars feature a variety of interactive topics to help improve specific health risks. Seminars are approximately 10 to 15 minutes long and can be viewed at any time in the comfort of your home. • Wellness challenges - quarterly health challenges to help improve your health. C*hallenges last four to six weeks.* • Medical resources - members can find information online regarding common health issues to improve their health. • Health encyclopedia - online access to information on thousands of health topics, including disease, drug information, health news, recipes and more. • Interactive tools - check out the online virtual trainer, sandwich maker, calculators and health quizzes designed to help you improve your health. **Subscription to *Healthier U Bits & Bytes* -** a monthly electronic newsletter highlighting healthy living tips, community events and your HealthPlus benefits. **Personalized resources -** continuing to support you in your efforts to stay healthy at no additional cost to you including: **Healthier U™ Welcome Communication -** provides an overview of all the resources available to you as a member of HealthPlus and at no extra cost. **Live Health Coaches -** a personal health coach to work with you via phone, email or online chat to assist you in reaching your goals for a healthier lifestyle such as losing weight or quitting tobacco use. **Disease Management & Care Counselors -** a team of professional staff, nurses, counselors and dietitians to assist you in managing your chronic condition or to help you through an acute illness or incident.
HealthPlus Perks	Discounts on programs and services such as Weight Watchers®, Snap Fitness, Curves, Anytime Fitness, Door to Door Organics, Dunham's Sports and more.
Online convenience care (virtuwell™)	Virtual visits to diagnose and treat common conditions lika cold, flu, sinus, ear pain when your PCP office is closed and/or the condition does not warrant a visit to an Urgent Care Center. Visit www.virtuwell.com for online care.

Learn more about your HealthPlus Wellness at www.healthplus.org/healthieru or call 1-866-810-4540.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, (800) 332-9161 or visit their website at www.healthplus.org.

HealthPlus Signature HMO Plans for Individuals and Families

- HealthPlus Signature HMO Plans are designed for pre-65 individuals or families who reside in the HealthPlus service area and are *not* covered by an employer or government-sponsored program.
- In these times of economic shifts and workforce reductions, HealthPlus Signature provides peace of mind with comprehensive coverage and flexibility and is perfect for people who are:
  - Coming off a parent's employer-sponsored coverage
  - Self-employed
  - Facing a layoff
  - Considering early retirement
  - Losing their employer-sponsored health coverage
  - Between jobs or just starting a job
  - Domestic Partners of Federal Employees

HealthPlus has designed unique health plans for individuals and families that combine affordable low monthly medical premiums with preventive care coverage.

- Buy direct from HealthPlus – it's the simpler and easier alternative to purchasing health care benefits on the government marketplace exchange
- ACA-compliant Silver and Bronze HMO plans include the required essential health benefits plus there is no medical underwriting or pre-existing condition exclusions
- National provider network – coverage travels with members in all 50 states and includes national centers of excellence like Mayo, Cleveland Clinic and Johns Hopkins

You can sign up for a Signature HMO plan if you have a qualifying life event or, during the next individual health insurance enrollment period!

For more information or to enroll, visit us online at HealthPlus.org/Signature.html or call one of our friendly representatives at 877-562-0907.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For more information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services***.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Sex transformation surgery and all expenses in connection with such surgery.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital and other benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at (800) 332-9161, or at our Web site at www.healthplus.org.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

HealthPlus of Michigan
Attn: Claims
2050 S. Linden Rd.
P.O. Box 1700
Flint, MI 48501-1700

Note: Charges for the completion of claim forms, interest on late payments, or charges for failure to keep scheduled appointments are not covered.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service Department at (800) 332-9161. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) the end of the time frame whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with a written or electronic notification within three days of oral notification.

Concurrent care claims procedures

A concurrent claim involves care provided over a period of time of over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or treatment is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you fail to follow these pre-service claims procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure, or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situation in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Section 3, 7 and 8 of this brochure, please visit www.healthplus.org.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admission.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to us at 2050 South Linden Road, P. O. Box 1700, Flint, MI 48501-1700 or calling us at (800) 332-9161.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take in account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decision regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: 2050 South Linden Road, P. O. Box 1700, Flint, MI 48501-1700; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; and e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in Step 4.
2	In the case of a post-service claim, we have 45 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or

c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to file a lawsuit. if you decide to file a law suit you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a **serious of life threatening condition** (one that may cause permanent loss of bodily function or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (800) 332-9161. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM' Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant, or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage".

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan covers some of these costs, providing the plan determines the services are medically necessary. (For further information, see Page 63.) We strongly encourage your physician to contact the plan to discuss specific services if you participate in a clinical trial.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048).
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We (HealthPlus of Michigan) offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the imporant disclosure notice from us about the FEHB prescription drug coverge and Medicare. The notice is on the first inside page ofthis brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Secruity Association online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY: 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you were covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required.

Claims process when you have the Original Medicare Plan – You probably do not need to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payor, we process the claim first.
- When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at (800) 332-9161 or see our website at www.healthplus.org.

We waive some costs if the Original Medicare Plan is your primary payor – When Original Medicare is the primary payor, we will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive Part B deductible, 20% of Medicare approved amounts and Part B excess charges. You will only be responsible for your member copyaments.

Please review the following table. It illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$0	$0
Out of Pocket Maximum	$6,350 self only/$12,700 family	$6,350 self only/$12,700 family
Primary Care Physician	$20	$20
Specialist	$40	$40
Inpatient Hospital	$500 per admission	$500 per admission
Outpatient Hospital	$0	$0
Rx	Tier 1 -$20 Tier 2 -$40 Tier 3 - $80 Tier 4 – Specialty (30 day supply) 25% up to $250	Tier 1 -$20 Tier 2 -$40 Tier 3 - $80 Tier 4 – Specialty (30 day supply) 25% up to $250
Rx – Mail Order (90 day supply)	21/2 x retail copay	2 1/2 x retail copay

You can find more information about how our plan coordinates benefits with Medicare at www.healthplus.org.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227),(TTY: 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

• **Medicare prescription drug coverage (Part D)**	When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Acute care service	The provision of highly concentrated care to patients requiring comprehensive observation, continuous monitoring, and treatment with immediate Physician intervention when necessary due to the seriousness or unstable nature of the illness or injury.
Affiliated provider	A provider who has agreed in writing to provide services to Members.
Appropriate referral	A referral from your Primary Care Physician to another provider. Note: A specialist may not provide a referral.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	An approved clinical trial includes a phase I, phase II, phase III or phase IV clinical trail that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition and is ether Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. • Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	Coinsurance is the percentage of allowance that you must pay for your care. See page 20.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 20.
Cost-sharing	Cost-sharing is the general term used to refer your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Short term, Non-skilled care, furnished for the purpose of meeting non-medically necessary personal needs, such as assistance in walking, dressing, bathing, eating and taking medications. Custodial care lasting 90 days or more is sometimes known as Long term care, neither of which are covered by this Plan.
Day treatment mental health and/or substance abuse services	Generally accepted therapeutic services and/or ancillary services which last four (4) or more consecutive days.
Dental care	Services or procedures which concern maintenance or repair of the teeth and/or gums or are performed to prepare the mouth for dentures.
Dentist	An individual licensed under the Act or any licensing statute or law of the applicable governing state or governmental unit to engage in the practice of dentistry.
Durable medical equipment	Equipment of the type approved by the Plan which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury.

Experimental or investigational services	A service that is of doubtful medical usefulness or effectiveness to the Member, as assessed by local medical community standards.
Freestanding emergency center	A Facility which is licensed, certified, or otherwise authorized pursuant to the Act or any similar licensing statute or law of its governing state or governmental unit to provide services in emergencies or after hours.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Hearing aid	An electronic device of the type approved by HPM worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if medically necessary.
Home health agency	A facility or program which is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit and is approved to provide home health services.
Hospice	A Provider which is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit to supply pain relief, symptom management, and supportive services to individuals suffering from a disease or condition with a terminal prognosis.
Hospital	An acute care general facility which: (1) provides inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of duly licensed Physicians; (2) is licensed, certified, or otherwise authorized pursuant to the Act or other similar licensing statute of its governing state or governmental unit; and (3) which is not, other than incidentally, a place of rest, a place for the aged, a nursing home, or a facility for the treatment of substance abuse or pulmonary tuberculosis.
In-network benefits	The provision of Covered Services by: (A) The Member's Primary Care Physician; (B) A Provider to whom the Member is Appropriately Referred; or (C) An Affiliated Provider when a referral or other authorization is not required by the Plan.
Intermediate care	As it applies to Mental Health and Substance Abuse Services, the use of a full or partial residential therapy setting (also known as Residential and Day Treatment programs), and shall include generally accepted therapeutic techniques and other therapeutic and ancillary services.
Intermittent skilled nursing care	Services provided by a licensed nurse to a Member who has a medically predictable recurring need for skilled care at least once in every sixty (60) day period.
Medical necessity	The health care associated with the Member is consistent with and called for in relationship to the intensity of service, severity of illness, and appropriateness of services provided.
Medicare	Title XVIII of the Social Security Act and all amendments thereto.
Members	The Subscriber and his/her Dependents covered under this Contract.
Non-affiliated provider	A Provider who has not agreed in writing to provide services to Members.
Non-plan physician	A Physician who has not entered into a written contract to provide services to Members.
Orthotic appliance	An apparatus of the type approved by the Plan which is used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body.

Out-of-network benefits	The provision of Covered Services by: (A) A Non-Affiliated Provider, unless Appropriately Referred; (B) An Affiliated Provider (other than the Member's Primary Care Physician) to whom the Member was not Appropriately Referred; or (C) A Provider under any other circumstances which does not meet the definition of an In-Network Benefit.
Out-of-pocket maximum	The limit of costs that a member must pay for covered services during each benefit year.
Outpatient mental health and/or substance abuse services	Therapeutic services which last less than (4) consecutive hours.
Pharmacy	A business licensed under the Act or similar licensing statute or law of its governing state or governmental unit to engage in the practice of pharmacy.
Physician	An individual licensed under the Act or other similar licensing statute or law of the applicable governing state or governmental unit to engage in the practice of allopathic medicine, osteopathic medicine, chiropractic, or podiatric medicine and surgery.
Plan physician	Any Physician who has entered into a written contract to provide services to Members.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Preferred mental health provider	An Affiliated Provider specializing in the treatment of mental illness who is both selected by a Member for his/her care and is designated by the Plan as a Preferred Mental Health Provider.
Preferred substance abuse provider	An Affiliated Provider specializing in the treatment of substance abuse who is both selected by a Member for his/her care and is designated by the Plan as a Preferred Substance Abuse Provider.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Prosthetic device	A device that replaces all or a part of an internal body organ or external body member, or that replaces all or a part of the function of a permanently inoperative or malfunctioning internal body organ or external body member.
Provider	A health professional, facility, or agency complying with the Act or other similar licensing statute of the applicable governing state or governmental unit. The following services are not covered: Services which are provided by individuals who are not licensed/certified under the Michigan Public Health Code (or other similar code/statute of any other state or government unit) or services which are beyond the treating individual's licensing.
Reasonable charge	The lesser of the treating Provider's charge or the amount determined to be a fair charge by the Plan in comparison to charges of other Providers in the same geographic region.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Residential substance abuse program	A course of treatment which requires twenty-four (24) hour on-site presence coupled with the continuous availability of intense drug and alcohol therapy.
Residential treatment	Treatment provided in a state-licensed subacute facility with structured, licensed Practitioners. This treatment must be medically-monitored and must include access to: (i) medical services 24 hours per day, 7 days per week; (ii) nursing services 24 hours per day, 7 days per week; and (iii) Physician on-call availability for emergency 24 hours per day, 7 days per week.
Semi-private room	A room containing two (2) or more patient beds in an inpatient facility.
Short-term	Service for a condition which the Plan determines can be expected to significantly improve within a period of sixty (60) days.
Skilled care service	Concentrated observation, monitoring, evaluation, and intervention by licensed and trained personnel under the direction of a Physician and usually does not require daily intervention for conditions that are stable or stabilizing.
Skilled nursing facility	A facility licensed to provide Skilled Nursing Care in accordance with the Act or other similar licensing statute of its governing state or governmental unit.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Us/We	Us and We refer to HealthPlus of Michigan.
You	You refers to the enrollee and each covered family member.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without care or treatment that is subject of the claim. Urgent care claims usually involve Pre-serve claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at (800) 332-9161. You may also prove that your claim is urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB program.

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary BEFORE taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500.00. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA) –**Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
  FSAFEDS offers paperless reimbusement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA) –** Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26)
- **Dependent Care FSA (DCFSA) –** Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans will provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB Plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY: 1-800-843-3557), or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Notes

Notes

Summary of benefits for HealthPlus of Michigan - 2016

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	• $20 primary care • $40 specialist	24
Services provided by a hospital:		
• Inpatient	$500 copay per admission	41
• Outpatient	Nothing	42
Emergency benefits:		
• In-area or out-of-area	• $20 per office visit • $40 per urgent care center visit • $200 per hospital visit	45
Mental health and substance abuse treatment:	Regular cost-sharing	46
Prescription drugs:		
• Retail pharmacy (up to a 30-day supply)	$20 generic/$40 formulary brand/$80 non-formulary brand - 25% copay with $250 maximum per fill for specialty medications at certain specialty pharmacies	50
• Retail Pharmacy or mail order (90 day supply)	$50 per generic/$100 per formulary brand/ $200 per non-formulary brand	50
Wellness Program: Biometric Screening/Health Assessment incentives offered.	Nothing	32
Dental care (Accidental injury benefit only)	Nothing	51
Vision care	Initial pair of glasses after cataract surgery covered with $0 copay.	30
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Your annual out-of-pocket expenses for covered services, including copayments and coinsurance, cannot exceed $6,350 for Self Only enrollment, or $12,700 for Self Plus One or Self and Family coverage.	19

2016 Rate Information for HealthPlus of Michigan

For 2016 health premium information, please see: http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.