Priority Health

prioritypriorityhealth.com/federal

Customer Service: 616 942-1221 or 800 446-5674

2015

A Health Maintenance Organization (high and standard option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides.

Serving: The Lower Peninsula of Michigan

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 12 for service area.

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 13
- Summary of benefits: Page 87

NCQA excellent accreditation

Enrollment codes for this Plan:

LE1 High Option - Self Only
LE2 High Option - Self and Family
LE4 Standard Option -Self Only
LE5 Standard Option - Self and Family

Special Notice

This Plan is being offered for the first time under the Federal Employees Health Benefits Program during the 2014 Open Season.

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-884

Important Notice from Priority Health About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Priority Health 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 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 Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program 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 Priority Health under our contract (CS 2944) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 616 942-1221 or 800 446-5674 or through our website: customerservice@priorityhealth.com.

The address for Priority Health's corporate office is:

Priority Health
1231 East Beltline NE
Grand Rapids, MI 49525

This brochure is the official statement of benefits. No oral 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. You do not have a right to benefits that were available before January 1, 2015 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually.

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.

The ACA establishes a minimum 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 Priority Health.
- 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 health care providers, 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) that you receive from us.

- Periodically review your claim 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 616 942-1221 or 800 446-5674 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/oig

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 is 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 reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

-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 Priority Health 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 minumum 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/insure/health 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 a *Guide to Federal Employees Health Benefits Plans,* 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
  - What 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 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 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 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 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 health benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members 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.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren (including children of same-sex domestic partners in certain states) 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 spouse 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 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 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 and Family coverage 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 and Family 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 and Family 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. 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 2015 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 2014 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).

- **Upon divorce**

If you are divorced from a Federal employee, or 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 RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

- **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, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* 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 FEHBP 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 616 942-1221 or 800 446-5674 or visit our website at *priorityhealth.com.*

- **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 website 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. We give you a choice of enrollment in a High Option or Standard Option.

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**,** coinsurance, and deductibles 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.

General features of our High and Standard Options

Our High Option Features little, if any, out of pocket expenses. Our Standard Option offers benefits with slightly higher out-of-pocket expenses, including a deductible, but at a lower premium cost to you. Both options provide access to Priority Health's high quality service.

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

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 deductible, copayments or coinsurance.

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Annual deductible

There is no deductible under our High Option. Under the Standard Option, the annual deductible of $350 single and $700 family must be met before plan benefits are paid for care other than preventive care services.

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $6,600 for Self Only enrollment, or $13,200 Self and Family coverage.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and providers. 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 also available from our Customer Service department, including:

- Our current Provider Directory.
- The professional credentials of our participating plan providers. This includes, but is not limited to, providers who are board certified in the specialty of pain medicine and the evaluation and treatment of chronic or acute pain.
- The telephone number of the Michigan Department of Licensing and Regulatory Affairs where you can call to find out information regarding disciplinary actions or formal complaints filed against a provider.
- Prior approval requirements and any limitations, restrictions or exclusions on services, benefits or providers.

- Clinical review criteria we use to determine whether services or supplies are medically/clinically necessary in a particular situation.
- The type of financial relationships between us and our in-network providers.
- How we evaluate new technology for inclusion as a covered service.
- How we evaluate new drugs for inclusion on our approved drugs list.
- A printed version of this brochure.

If you want more information about us, call 616 942-1221 or 800 446-5674, or write to Priority Health, 1231 East Beltline NE, Grand Rapids, MI 49525. You may also visit our website at *priorityhealth.com*.

Protecting Your Privacy

The Priority Health Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is available on our website priorityhealth.com or by calling our Customer Service Department at 616 942-1221 or 800 446-5674.

If you want more information about us, call 616 942-1221 or 800 446-5674, or write to Priority Health, 1231 East Beltline NE, Grand Rapids, MI 49525. You may also visit our website at *priorityhealth.com*.

Your medical 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. We will not disclose information from your medical records without your consent, except as allowed in accordance with our Notice of Privacy Practices.

Service Area

To enroll with us, you must live or work in our Service Area. This is where our providers practice. Our service area includes the Lower Peninsula of Michigan.

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 and urgent 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 moves outside of our service area, you can enroll in another plan. You do not have to wait until Open Season to change plans. Contact your employing or retirement office. If you have dependent children living outside our service area (such as a child attending college in another state), notify Priority Health. He or she may be eligible for out of area dependent coverage. Contact us for additional information.

Section 2. We are a new plan

This Plan is new to the FEHB Program. We are being offered for the first time during the 2015 Open Season.

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 616 942-1221 or 800 446-5674 or write to us at: Priority Health, 1231 East Beltline NE, Grand Rapids, MI 49525. You may also request replacement cards through our website: priorityhealth.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. Our Open Access program allows you to receive covered services from a participating Plan provider without a required referral from your primary care physician (PCP) or another Plan provider in the network.

- **Plan providers**

Plan providers are physicians and other health professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

Each member must designate one of our Plan providers as his or her primary care physician (PCP). Each family members may select his or her own in-network primary care physician. A PCP may refer a member to another participating Plan provider when it would be more appropriate for him or her to receive care from a different type of health professional or specialist. Members may also choose to seek care from any in-network specialist without a PCP referral.

We list Plan providers in our Provider Directory, which we update periodically. Members can access our Provider Directory by using our online Find A Doctor tool at priorityhealth.com. This tool makes it easy for members to search for health care providers and facilities nationwide. Members enter plan type and location, and can search by primary care physician, hospital, pharmacy and other facility/service. The tool provides members with:

- Provider name
- Gender
- Network status
- Distance
- Address
- Office hours
- Map

In addition to the online tool, a member can call our customer service department at 616 942-1221 or 800 446-5674 and a representative will help him or her find a doctor or facility.

- **Plan facilities**

Plan facilities and hospitals are located throughout Michigan. Priority Health contracts with these facilities to provide covered services to our members. We list these in the Provider Directory and update the information periodically.

As stated under Plan Providers above, members can search for plan facilities by accessing our online Find A Doctor tool at priorityhealth.com. This tool makes it easy for members to search for health care providers and facilities nationwide. In addition to the online tool, a member can call our customer service department at 616 942-1221 or 800 446-5674 and a representative will help him or her a doctor or facility.

What you must do to get covered care

We require your PCP and other Plan providers to discuss all treatment options available to you whether the treatment or services are covered or not covered . Providers are not expected to know when services have limitations or are excluded from coverage. The Brochure provides you with this information.

Your PCP or other health professionals may recommend, and you may choose, treatment options even if they are not covered or are limited by this Plan. You are required to pay for any services you receive that are not covered or that exceed your maximum benefit.

- **Primary care**

Your PCP provides your primary health care, orders lab tests and x-rays, prescribes medicines or therapies and arranges hospitalization when necessary. Your PCP may be a family practitioner, a general practitioner, an internal medicine specialist, a pediatrician, an obstetrician/gynecologist, a nurse practitioner or a physician assistant. Each family members may select his or her own in-network primary care physician.

If you do not select a PCP, we will assign one to you. You can change your PCP at any time, including one assigned to you, except while you are in the hospital. You may also change the PCP of a minor or covered dependent who is incapable of choosing a PCP. All changes are effective on the first day of the month after we receive your request unless you are changing a child's pediatrician. Pediatrician changes are effective immediately.

You may choose to seek services from a Plan provider without referral from your PCP at any time. For example, a woman can see a participating Plan obstetrician/gynecologist without referral from her PCP. However, we recommend you talk with your PCP about any issues concerning your medical care, and contact him or her before you receive medical services, except in a medical emergency. Working with your PCP improves the coordination and continuity of care you receive. When necessary, your PCP will work with other participating Plan providers and specialist providers to ensure you receive the care you need.

We recommend you receive a physical examination from your PCP within one year of joining Priority Health.

- **Specialty Care**

Specialty care is care provided by a health professional or physician other than your PCP. This care may be provided by both Plan providers and non-network providers. Plan providers are those listed in our Provider Directory.

You do not need a referral from your PCP or Priority Health to see a Plan provider for most covered service. Only certain services, when provided by your PCP or a Plan provider require prior approval. Additional information about prior approval requirements is included below.

Non-Network Providers

All covered services you receive from non-network providers must be prior approved by us. If the standard of care (medically appropriate treatment) for your condition is not available from a Plan provider, your PCP may ask Priority Health for approval to refer you to a non-network provider. If you do not receive approval from Priority Health prior to seeking covered services from a non-network provider, or if we determine the medically appropriate treatment for your condition is available from a Plan provider, you will be responsible for payment. A referral from your PCP or another Plan provider is not enough if you want the services to be covered. If Priority Health approves the referral, we will notify your PCP or the Plan provider who makes the request.

A Second Medical Opinion

It is often appropriate to ask for a second medical opinion before receiving certain treatments for health conditions and before many proposed surgeries. You may request a second medical opinion from a Plan specialist who has skills and training substantially similar to those of the physician making the original treatment recommendation without prior approval. If there are no Plan providers with the skills and training needed to provide a second opinion on the proposed treatment, we may cover a second medical opinion from a non-network specialist . Prior approval from Priority Health is required before the second opinion is obtained. Any tests, procedures, treatments or surgeries recommended by the consulting provider must be performed by a Plan provider unless we approve the services in advance.

Occasionally, Priority Health may require that you get a second opinion from a Plan specialist that we have chosen. This second medical opinion is used to assist us in determining whether services or supplies are medically/clinically necessary according to our medical and behavioral health policies or adopted criteria.

Termination of Provider's Participation.

Plan providers contract with us to provide covered services to members. Either the Plan provider or Priority Health can terminate that contract at any time. We cannot guarantee that you will be able to receive services from a specific Plan provider while you are covered under this Plan. We will notify you if your PCP is no longer a Plan provider so you can select another PCP. If your specialist terminates his or her participation with Priority Health, you can contact your PCP for a recommendation of a new specialist to visit. Our Customer Service department is also available to assist you in finding another Plan provider and in receiving care during the transition to a new provider. If you have any questions, please call our Customer Service department.

If you are being treated by a participating Plan provider whose contract with us is terminated, you may be allowed to continue seeing that provider for a limited time. So long as the provider is able to continue treating you, you can receive covered services if, at the time of the provider's contract termination:

1. you are receiving on-going care. You may continue to see this provider for up to 90 days or until Priority Health makes other arrangements for you to receive the same services from another Plan provider.

2. you are undergoing treatment for a chronic or disabling condition, or are in the second or third trimester of pregnancy. You may continue to see this provider for up to 90 days, or through completion of postpartum care.
3. you are undergoing treatment for a terminal Illness. You may continue to be treated by this provider for the remainder of your life.

If the Plan provider's contract with Priority Health has been terminated for quality of care reasons, we will not cover any care you receive from him or her.

You may also be able to continue seeing your specialist for up to 90 days after you receive a notice of change if you have a chronic and disabling condition and will lose access to your specialist because we:

1. terminate our contract with your specialist for reasons other than for cause;
2. drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
3. reduce our services area and you enroll in another FEHB plan.

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

- **Hospital care**

Your PCP 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 your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 616 942-1221 or 800 446-5674. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses 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; or
- 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 case, 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 PCP arranges most referrals to specialists and inpatient hospitalization, only care shown under *Other Services* requires prior approval by Priority Health in order to be covered under this Plan. For a more detailed list of care that requires prior approval, call our Customer Service department or go to our website *priorityhealth.com*. This list may change periodically as new technology and standards of care emerge.

- **Inpatient hospital admission**

Prior approval is required before all inpatient hospital admissions, including those for mental health and substance abuse. We will evaluate the medical necessity of your proposed stay and the number of days required to treat your condition, in order to make our decision.

You do not need prior approval from your PCP or Priority Health to seek care in a medical emergency or when urgent care is needed. Additionally, inpatient hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section do not require prior approval. However, we encourage you to notify us at least 60 days before your due date so we are better prepared to assist you at that time.

- **Other services**

You do not need prior approval from either your PCP or us for most services. For certain services, however, your treating physician must obtain prior approval from us, including any services he or she is recommending you obtain from a non-network provider. Before giving approval, we will consider if the service is covered, medically/clinically necessary and follows generally accepted medical practice. If coverage for services from a non-network provider is being requested, we also determine if the medically appropriate care is available from a Plan provider. Below are the services and supplies that require prior approval by Priority Health:

- Referrals to non-network providers.
- Transplants and evaluation for transplants
- Outpatient services
- Non-hospital facility services (including skilled nursing facility care)
- Radiology examinations
- High-tech radiology examinations, including but not limited to:
  - positron-emission tomography (PET) scans
  - magnetic resonance imaging (MRI)
  - computed tomography (CT scans)
  - nuclear cardiology studies.
- Reconstructive surgeries, including:
  - Paniculectomy
  - Rhinoplasty
  - Septorhinoplasty
- Bariatric Surgery
- Durable medical equipment (DME) charges over $1,000 and all rentals
- Prosthetics and orthotics charges over $1,000 and all shoe inserts
- Simulators
- Selected injectable drugs
- Home health care, including home infusion services and intermittent skilled services
- Services for treatment of Autism Spectrum Disorder
- Supplemental feedings administered via tube or IV
- Genetic testing
- Clinical trials and any services considered experimental, investigational or unproven
- Comprehensive pain and headache programs
- Additional items as outlined on our website

How to request prior approval for an inpateint admission or for other services

To obtain prior approval, you or your provider must call the applicable number below:

- for mental health or substance abuse services – 800 673-8043
- for any other covered services that require approval – 800 828-8302.

- **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 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.

- **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 provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to 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 616 942-1221 or 800 446-5674. You may also call OPM's Health Insurance 1 at (202) 606-0727 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 616 942-1221 or 800 446-5674. 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 or 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 notify us within 48 hours or as soon as reasonably possible following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

Inpatient hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section do not require prior approval. However, we encourage you to notify us at least 60 days before your due date so we are better prepared to assist you at that time.

If delivery occurs in the hospital, The Hospital length of stay for the mother or newborn begins at the time of delivery (or in the case of multiple births, at the time of the last delivery). If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

- **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 prior approval rules when using non-network facilities

It is important to get prior approval so you know ahead of time if the services or supplies you seek will be covered. If the required prior approval is not obtained, we may review the claim after you receive the services. If we determine that the care received was medically/clinically necessary and provided by a non-network provider, the care may only be covered if the necessary care is unavailable from a Plan provider. If we determine that the care received was not medically/clinically necessary or the care was provided by a non-network provider when it could have been provided by a Plan provider, the services will not be covered.

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 prior approval of an inpatient admission or other services, you may request a review in accord 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 unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request.

1. Prior approve 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 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. 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

Below are the out-of-pocket costs you will pay for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to any of your out-of-pocket costs for the covered services you receive, such as deductible, coinsurance, and copayments.
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, under the High Option you pay a copayment of $10 per office visit. When you see your primary care physician under the Standard Option, you pay a copayment of $15 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. Copayments do not count toward any deductible. Coinsurance does not apply until you meet your calendar year deductible, if applicable. There is no deductible for the High Option. There is a $350 single / $750 family deductible for the Standard Option.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doe not apply until you have met your calendar year deductible, if applicable. Example: In our Plan, you pay 50% of our allowance for infertility drugs and durable medical equipment.
Your catastrophic protection out-of-pocket maximum	We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles, coinsurance and copayments, cannot exceed $6,600 for Self Only enrollment, or $13,200 Self and Family coverage. Once you reach this overall maximum, covered services will be covered at 100% with no cost to you. Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.
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 your 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. Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.
When Government facilities bill us	Facilities of the Department of 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 and Standard Option Benefits

Page 66 and page 67 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5 High and Standard Option Benefits Overview

We're a Michigan-based health plan nationally recognized for improving the health and lives of our members – ensuring you get the best care, at the best price, when and where you need it.

Our plans:

• Help you be your healthiest with confidential and personal support from our on-staff health coaches and nurses
• Show you the cost and quality of the care you receive — and are likely sharing the cost of — before you seek services
• Allow you to see an in-network specialist without a referral
• Get you care where and when you need it — with 24-hour virtual visits
• Provide access to care if you're sick or injured and away from home

We're more than just a health plan – we're a healthier approach to health care.

This Plan offers both High and Standard Options. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read the *Important things you should keep in mind* at the beginning of each subsections. Also read the General exclusions in Section 6; they apply to all the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about the High and Standard Option benefits, contact us at 616 942-1221 or 800 446-5674 or on our website at priorityhealth.com.

Each option offers unique features.

- **High Option** — The High Option offers a high level of comprehensive benefits. This option will cost slightly more than the Standard Option in premiums, but will offer a higher level of benefits. The High Option includes, but is not limited to, the following:
  - No deductible for single or family coverage.
  - 100% coverage for hospitalization.
  - $10 Copay for Non-preventive Primary care office visits.
  - $30 copayment for Specialist office visits.
  - A $10 Generic/ $40 Brand / $60 Non-Preferred Brand co-payment for prescription drugs.
  - 20% coinsurance for preferred speciality ($100 limit for 31 day supply)
  - 20% coinsurance for non-preferred specialty ($200 limit for 31 day supply)

- **Standard Option** — The Standard Option offers the same high level of service that comes with the High Option. This option has slightly lesser benefits, but will cost you less in premiums. The Standard Option includesthe following differences:
  - A $350 single and $700 family deductible.
  - A 20% coinsurance for hospital services.
  - A $15 copayment for Primary Care office visits.
  - A $30 copayment for Specialists office visits.
  - A $10 Generic/ $45 Brand / $90 Non-Preferred Brand co-payment for prescription drugs.
  - 20% coinsurance for preferred speciality ($150 limit for 31 day supply).
  - 20% coinsurance for non-preferred specialty ($300 limit for 31 day supply).

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

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/clinically necessary.
- Plan physicians must provide or arrange your care.
- A facility copayment applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible under the Standard Option is: $350 per person and $700 per family. The calendar year deductible applies to most benefits in this Section.
- There is no calendar year deductible under the High Option.
- 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**	**Standard Option**
Professional services of physicians • In physician's office • Telephonic visits • Through secure electronic portal	• $10 copayment per PCP office visit • $30 copayment per specialist office visit	• $15 copayment per PCP office visit • $30 copayment per specialist office visit • Deductible does *not* apply
Virtual Visits	$10 copayment per office visit	• $15 copayment per office visit • Deductible does *not* apply
Professional services of physicians • During an inpatient or outpatient hospital stay • At an ambulatory surgery center • For office based vasectomy services	No charge	No charge
At home	No charge	No charge
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Advanced Diagnostic Imaging Services (Such as CT, CTA, MRI, MR, Nuclear Cardiology studies, PET scan) Note: Prior approval required for certain radiology examinations. For additional information, see *Other Services* under *You need prior Plan approval for certain services* in Section 3.	• $150 copayment (copayment waived if performed while confined in a hospital as an inpatient) • Maximum 10 copayments per individual per contract year	• $150 copayment (copayment waived if performed while confined in a hospital as an inpatient) • Deductible applies • Maximum 10 copayments per individual per contract year
Standard radiology examinations and laboratory procedures (in a non-Hospital facility or physician's office)	• No charge	• 20% coinsurance • Deductible applies

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
	• Appropriate office visit copayment (PCP or specialist) may apply for office services	• Appropriate office visit copayment (PCP or specialist) may apply for office services
Not covered Services related to dental care are excluded	*All charges*	*All charges*
Preventive care, adult	**High Option**	**Standard Option**
Certain Immunizations endorsed by the Centers for Disease Control and Prevention (CDC) (Doses, recommended ages, and recommended populations vary)	No charge	No charge
Certain Drugs • Aspirin – men and women of certain ages • Folic Acid supplements – women who may become pregnant • Vitamin D supplements – Adults age 65 and older at risk for falls	No charge	No charge
Screening and Counseling Services for Men and Women • Abdominal Aortic Aneurysm – men of specified ages who have ever smoked (one-time only) • Alcohol misuse – all adults • Blood pressure – all adults • Cholesterol – adults of certain ages or adults at higher risk • Colorectal cancer – adults age 50 to 75 • Depression – all adults • Type 2 diabetes – adults with high blood pressure • Diet counseling – adults at higher risk for chronic disease • Hepatitis C virus infection – all adults at high risk and one time for all adults born between 1945 and 1965 • HIV – all adults at higher risk and all pregnant women • Lung cancer screening (including annual low-dose CT scan) – Adults age 55 to 80 with a 30 pack-year smoking history who currently smoke or have quit within the past 15 years. • Obesity – all adults • Sexually Transmitted Infection (STI) – prevention counseling for adults at higher risk	No charge	No charge

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Tobacco use – all adults (includes cessation interventions for tobacco users) • Syphilis – all adults at higher risk	No charge	No charge
Screening and Counseling Services for Women Only (Including Pregnant Women) • Anemia – on a routine basis for pregnant women • Bacteriuria (urinary tract or other infection screening) – pregnant women • BRCA risk assessment and genetic counseling and BRCA testing (if indicated after counseling) – women at higher risk • Breast cancer mammography – every 1 to 2 years for women over 40 • Breast cancer preventive medication – women at higher risk • Breast feeding – interventions to support and promote breast feeding, prescribed supplies and counseling • Cervical cancer – sexually active women • Chlamydia infection – younger women and other women at higher risk • Counseling and screening for human immune-deficiency virus - sexually active women • Counseling for sexually transmitted infections - sexually active women • Gestational Diabetes Mellitus – pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes • Gonorrhea – all women at higher risk • Hepatitis B – pregnant women at their first prenatal visit • Human papilloma virus testing - women age 30 and over • Intimate partner violence – women of childbearing age • Osteoporosis – women over age 60 depending on risk factors • Rh Incompatibility – all pregnant women and follow-up testing for women at higher risk • Tobacco use – all women, and expanded counseling for pregnant tobacco users • Screening and counseling for interpersonal and domestic violence - all women	No charge	No charge

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Screening for gestational diabetes - pregnant women • Syphilis – all pregnant women or other women at increased risk • Well-woman visits - all women • Women's prescribed contraceptive methods (including women's sterilization procedures) and counseling - women of childbearing age	No charge	No charge
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm See the Priority Health Preventive Health Care Guidelines for our most up-to-date list of covered preventive services. The guidelines are available on our website or you may call Customer Service.		
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, adoption, or travel.	*All charges.*	*All charges.*
Preventive care, children	**High Option**	**Standard Option**
Certain Immunizations endorsed by the Centers for Disease Control and Prevention (CDC) (Doses, recommended ages, and recommended populations vary)	No charge	No charge
Certain Drugs • Fluoride chemoprevention supplements – children without fluoride in their water source • Gonorrhea preventive medication – all Newborns • Iron supplements – children ages 6 to 12 months at risk for anemia	No charge	No charge
Assessments and Screenings for Children • Alcohol and drug use assessments – adolescents • Autism screening – children at 18 and 24 months • Behavioral assessments – children of all ages • Cervical Dysplasia screening – sexually active females • Congenital Hypothyroidism screening – Newborns • Developmental screening – children under age 3, and surveillance throughout childhood • Dyslipidemia screening – children at higher risk of lipid disorders	No charge	No charge

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
• Hearing screening – all newborns • Height, weight and Body Mass Index measurements – children of all ages • Hematocrit or Hemoglobin screening – children of all ages • Hemoglobinopathies or Sickle Cell screening – all Newborns • HIV screening – adolescents at higher risk • Lead screening – children at risk of exposure • Medical history – all children throughout development • Obesity screening and counseling – children of all ages • Oral Health Risk Assessment – young children • Phenylketonuria (PKU) Genetic Disorder screening – all newborns • Sexually Transmitted Infection (STI) prevention counseling – adolescents at higher risk • Tobacco use intervention – school-aged children and adolescents • Tuberculin testing – children at higher risk of tuberculosis • Vision screening – all children	No charge	No charge
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm See the Priority Health Preventive Health Care Guidelines for our most up-to-date list of covered preventive services. The guidelines are available on our website or you may call Customer Service.		
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, adoption, or travel.	*All Charges.*	*All Charges.*
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care	• Routine prenatal and postnatal visits are covered under the "Preventive Care" category above. • Attendance at an approved maternity education program is Covered at no charge.	• Routine prenatal and postnatal visits are covered under the "Preventive Care" category above. • Attendance at an approved maternity education program is Covered at no charge. Deductible does not apply.

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Standard Option**
NOTE: Inpatient Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section do not require Prior Approval. See Section 5(c) "Services provided by a hospital or other facility, and ambulance services" for Coverage related to maternity services, including delivery and nursery services	• Routine prenatal and postnatal visits are covered under the "Preventive Care" category above. • Attendance at an approved maternity education program is Covered at no charge. • Office/home visits and consultations for complications of pregnancy are covered as described under the "Diagnostic and treatment services" category above.	• Routine prenatal and postnatal visits are covered under the "Preventive Care" category above. • Attendance at an approved maternity education program is Covered at no charge. Deductible does not apply. • Office/home visits and consultations for complications of pregnancy are covered as described under the "Diagnostic and treatment services" category above.
Family planning	**High Option**	**Standard Option**
Women's prescribed contraceptive methods (including women's sterilization procedures) and counseling for all women of childbearing age	No charge	No charge
Vasectomy	• No charge for physician services when performed in physician's office. • No charge for physician services when performed in an inpatient or outpatient facility in connection with other covered inpatient or outpatient surgery. • No charge for outpatient and inpatient facility charges only when in connection with other covered inpatient and outpatient surgery.	• No charge for physician services when performed in physician's office. Deductible does *not* apply. • 20% coinsurance for physician services when performed in an inpatient or outpatient facility in connection with other covered inpatient or outpatient surgery. Deductible applies. • 20% coinsurance for outpatient and inpatient facility charges only when in connection with other covered inpatient and outpatient surgery. Deductible applies.
Tubal Ligation	• Physician services and outpatient facility charges are covered under Preventive Health Care Services category above.	• Physician services and outpatient facility charges are Covered under Preventive Health Care Services category above.

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**High Option**	**Standard Option**
	• Hospital inpatient care facility charges are subject to coinsurance and deductible when in connection with delivery or other covered inpatient surgery.	• Hospital inpatient care facility charges are subject to coinsurance and deductible when in connection with delivery or other covered inpatient surgery.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges.*	*All charges.*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility, including: • treatment of the underlying cause infertility • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs (see note below) Note: Injectible infertility and fertility drugs are covered under medical benefits. Oral infertility and fertility drugs are covered under the prescription drug benefit.	• 50% coinsurance • $30 copayment for artificial insemination	• 50% coinsurance • $30 copayment for artificial insemination
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies, including testing and medications, related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg.*	*All charges.*	*All charges.*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy serum	No charge	• No charge • Deductible does *not* apply
• Allergy serum	No Charge	No Charge
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*

Benefit Description	You pay	
Treatment therapies	**High Option**	**Standard 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 38. • Respiratory and inhalation therapy • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	• No charge • Appropriate office visit copayment may apply	• 20% coinsurance • Deductible applies • Appropriate office visit copayment may apply
Physical and occupational therapies	**High Option**	**Standard Option**
Rehabilitation services • Physical and occupational therapy (Including osteopathic and chiropractic manipulation) limited to a combined 60 visits per condition • Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 60 visits per condition	$10 copayment per visit	• $15 copayment per outpatient visit • Deductible does *not* apply
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Cognitive Therapy* • *Treatment of Autism Spectrum Disorder (see Autism Spectrum Disorder services section for physical and occupational services for treatment of Autism Spectrum Disorder)*	*All charges.*	*All charges.*

Benefit Description	You pay	
Speech therapy	**High Option**	**Standard Option**
60 visits combined with physical and occupational therapy and habilitative services per condition. *Not covered for the treatment of Autism Spectrum Disorder*	$10 copayment per visit	• $15 copayment per visit • Deductible does *not* apply
Autism Spectrum Disorder services	**High Option**	**Standard Option**
• Physical and Occupational Therapy • Speech Therapy • Applied Behavioral Analysis (ABA) Prior approval required for Applied Behavioral Analysis. Physical, occupational, and speech therapy and Applied Behavioral Analysis (ABA) coverage for treatment of Autism Spectrum Disorder is available for children and adolescents through the age of 18 only. Multiple co-pays may apply during one day of service.	$10 copayment per office visit	• $15 copayment per office visit • Deductible does *not* apply
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
One hearing screening, performed as part of a physical exam, during each calendar year to determine hearing loss.	No charge	No charge
Not Covered: • Services and supplies related to hearing care, including ear plugs, external BAHA devices, hearing aids and adjustments • Examinations for hearing aids, including examinations performed during a covered hearing screening	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
One vision screening, performed as part of a physical exam, during each calendar year to determine vision loss.	No charge	No charge
Not covered: • Eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses • Eye exercises, visual training, orthoptics, sensory integration therapy • Radial keratotomy, laser surgeries and other refractive keratoplasties • Refractions (tests to determine if eyeglasses are needed, and if so, what prescription)	*All charges*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Vision services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• All other vision care services	*All charges*	*All charges*

Benefit Description	You pay	
Foot Care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	• $10 copayment per office visit to your primary care physician • $30 copayment per office visit to a specialist	• $15 copayment per office visit to your primary care physician • $30 copayment per office visit to a specialist • Deductible does *not* apply
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*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic devices for the non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Prior Approval required for devices over $1,000	• 50% Coverage	• 50% Coverage • Deductible applies
• All orthotics with the exception of foot orthotics • Prior Approval required for devices over $1,000	• 50% Coverage	• 50% Coverage • Deductible applies
Not covered: *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* Lumbosacral supports • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Cochlear and other hearing implants*	*All charges*	*All charges*

Benefit Description	You pay	
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Hospital beds • Wheelchairs • Crutches • Walkers • Motorized wheelchairs when medically necessary • Blood glucose monitors • Insulin pumps Prior Approval required for devices over $1,000	• 50% Coverage	• 50% Coverage • Deductible applies
Not covered: • *Luxury or deluxe items, such as bath tub seats, reachers, raised toilet seats, vehicle modifications* • *Devices, braces used to affect performance in sport related activities* - *Duplicate Equipment* - *Items not medical in nature* - *Comfort/Convenience items such as power carts, bed boards, bathtub lifts, air conditioners, batteries, over the bed tables, home modifications* - *Disposable supplies i.e. sheets, gloves, diapers and bags* - *Exercise and hygienic equipment i.e. exercycles, bidets, toilet and bathtub/shower seats* - *Self-help devices not primarily medical in nature such as sauna baths, elevators and ramps, special telephone, computer or other electronic communication devices.* - *Implantable pumps* - *Experimental or research equipment* - *Devices/braces used specifically as safety items* - *Outpatient medical supplies including, but not limited to gauzes, tapes, and elastic bandages* - *Earplugs*	*All charges*	*All charges*

Benefit Description	You pay	
Home health services	**High Option**	**Standard Option**
• Intermittent skilled services furnished in the home by a physical therapist, occupational therapist, respiratory therapist, speech therapist, licensed practical nurse or registered nurse. • Prior Approval required except for Hospice Care services in the home	No charge	No charge
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.*	*All charges*	*All charges*

Benefit Description	You pay	
Chiropractic care	**High Option**	**Standard Option**
Spinal manipulations by a chiropractor	Covered under the "Physical and occupational therapy" category above	Covered under the "Physical and occupational therapy" category above
Not covered: *Any services, other than spinal manipulations, provided by a Chiropractor, even if the services are provided within the scope of the provider's license.*	*All charges*	*All charges*
Alternative integrative holistic health care	**High Option**	**Standard Option**
Not covered: Acupuncture and Non-traditional services, including but not limited to: • Massage therapy • Yoga • holistic/homeopathic treatment	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
• Smoking cessation programs • Education conducted by Plan providers about managing chronic disease states such as diabetes or asthma • Maternity classes conducted by Plan providers	No charge	No charge

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

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 for all of your care.
- 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.).
- **Prior approval is required for inpatient services except in an emergency.**
- The calendar year deductible under the Standard Option is: $350 per person and $700 per family. The calendar year deductible applies to most benefits in this Section.
- There is no calendar year deductible under the High Option.
- 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	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center, including: • 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) • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Treatment of burns	No charge when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center	20% coinsurance when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies
Certain Surgeries and Treatments (Physician fees only) • Bariatric Surgery • Reconstructive surgery - Blepharoplasty of upper lids - Breast reduction - Panniculectomy	• Physician fees are Covered at 50% of the first $2,000 for each certain surgery or treatment. No charge thereafter	• Physician fees are Covered at 50% of the first $2,000 for each certain surgery or treatment. No charge thereafter • Deductible applies

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
- Rhinoplasty - Septorhinoplasty - Surgical treatment of male gynecomastia • Skin disorder treatments - Scar revisions - Keloid scar treatment - Treatment of hyperhidrosis - Excision of lipomas - Excision of seborrheic keratoses - Excision of skin tags - Treatment of vitiligo - Port wine stain and hemangioma treatment • Varicose veins treatments • Sleep apnea treatment procedures Prior Approval required for bariatric surgery, panniculectomy, rhinoplasty and septorhinoplasty	• Physician fees are Covered at 50% of the first $2,000 for each certain surgery or treatment. No charge thereafter	• Physician fees are Covered at 50% of the first $2,000 for each certain surgery or treatment. No charge thereafter • Deductible applies
Not covered: • *Reversal of voluntary sterilization* • *Cosmetic surgery* • *Routine treatment of conditions of the foot; see Foot care*	*All charges.*	*All charges.*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect, congenital deformity or trauma, and/or a condition caused by injury or illness if: • The defects and/or effects of Illness or Injury cause clinical functional impairment. "Clinical functional impairment" exists when the defects and/or effects of illness or injury: - produced significant disability or major psychological trauma (psychological reasons do not represent a medical or surgical necessity unless you are undergoing psychotherapy for issues solely related to the Illness or Injury for which the reconstructive surgery is requested), - interferes with employment or regular attendance at school, - require surgery that is a component of a program of reconstructive surgery for a congenital deformity or trauma, or - contribute to a major health problem	No charge when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center	20% coinsurance when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• the condition can reasonably be expected to be corrected by such surgery • The services are approved in advance by us and you receive them within two years of the event that caused the impairment, unless either of the following applies: - The impairment caused by Illness or Injury was not recognized at the time of the event. In that case, treatment must begin within two years of the time that the problem is identified, or - Your treatment needs to be delayed because of developmental reasons. NOTE: We will Cover treatment to correct the functional impairment even if the treatment needs to be performed in stages as long as that treatment begins within two years of the event causing the impairment and as long as you remain a Member. Examples of congenital deformity or trauma include, but are not limited to: protruding ear deformities, cleft lip, cleft palate, certain birth marks, webbed fingers, and webbed toes.	No charge when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center	20% coinsurance when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies
In compliance with the Women's Health and Cancer Rights Act of 1998, we will consult with your PCP or other Participating Provider to determine Coverage for these services: • reconstruction of the breast on which the mastectomy was performed; • surgery and reconstruction to produce a symmetrical appearance on the other breast; • treatment of any physical complications, such as lymph edemas; • breast prostheses and surgical bras and replacements (see Prosthetic devices for more information) 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.	No charge for services provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center	20% coinsurance for services provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
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*	*All charges.*	*All charges.*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Treatment of fractures of the jaws or facial bones • Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental injury, including correction of cleft lip, cleft palate • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Biopsy and removal of tumors or cysts of the jaw, other facial bones, soft tissues of the mouth, lip, tongue, accessory sinuses, and salivary glands and ducts and incision of abscesses when done as independent procedures • Surgical services required to correct accidental Injuries, including emergency care to stabilize dental structures following Injury to sound natural teeth • Treatment of oral and/or facial cancer • Other surgical procedures that do not involve the teeth or their supporting structures	No charge for services provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center	20% coinsurance for services provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies
"Temporomandibular Joint Syndrome" or "TMJ" means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction. The following care for TMJ Syndrome is covered: • Medical care or services to treat dysfunction or TMJS resulting from a medical cause or Injury. • Office visits for medical evaluation and treatment. • X-rays of the temporomandibular joint including contrast studies, but not dental x-rays. • Myofunctional therapy. • Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.	50% coinsurance	• 50% coinsurance • Deductible applies

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
Orthoganathic Surgery This includes surgical treatment to restructure the bones or the other parts of the jaw to correct a congenital birth defect, the effect of an Illness or Injury or to correct other functional impairments. We will only Cover the following surgery services: 1. Referral care for evaluation and orthognathic treatment. 2. Cephalometric study and x-rays. 3. Orthognathic surgery and post-operative care, including hospitalization, if necessary.	50% Coinsurance	• 50% Coinsurance • Deductible applies
Not covered: • *Oral implants and transplants* • *Dental surgery in preparation for implants or dentures* • *Procedures that involve the teeth or their supporting structures including (such as the periodontal membrane, gingiva, and alveolar bone) including dentingious and odontogenic cysts.* • *Bite splints, orthodontic treatment, or other dental services to treat TMJ Syndrome* • *Orthodontic treatment, even when provided along with oral or orthognathic surgery*	*All charges.*	*All charges.*
Organ/tissue transplants	**High Option**	**Standard Option**
These solid organ transplants are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • 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	No charge	• 20% coinsurance • Deductible applies

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard 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)	No charge	• 20% coinsurance • Deductible applies
Blood or marrow stem cell transplantslimited 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 - Acutelymphocytic or 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) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency	No charge	• 20% coinsurance • Deductible applies

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • 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 - Ependymoblastoma - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	No charge	• 20% coinsurance • Deductible applies
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 or 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) - 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	No charge	• 20% coinsurance • Deductible applies

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- 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	No charge	• 20% coinsurance • Deductible applies
Additional allogeneic transplants, mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC), and/or autologous transplants may be covered if the trial is part of a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence only 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 patient's 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. • Autologous Transplants for the following are also covered: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma)	No charge	• 20% coinsurance • Deductible applies
National Transplant Program (NTP) -	*All charges*	*All charges*
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.	*All charges*	*All charges*
Not covered:	*All charges*	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	No charge	20% coinsurance Deductible applies

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

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/clinically necessary.
- Plan physicians must provide or arrange your care, and you must be hospitalized in a Plan facility.
- **Prior approval is required for inpatient services except in an emergency.**
- The calendar year deductible under the Standard Option is: $350 per person and $700 per family. The calendar year deductible applies to most benefits in this Section.
- There is no calendar year deductible under the High Option.
- 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).
- 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	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • 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 will be responsible for paying the additional charge above the semiprivate room rate.	No charge	• 20% coinsurance • Deductible applies
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 • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	No charge	• 20% coinsurance • Deductible applies
Not covered: • *Custodial care*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *Leave of absence or bed-hold charges incurred when you are on an overnight or weekend pass during an inpatient stay* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private duty nursing*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard 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.	No charge	20% coinsurance Deductible applies
Not covered: • *Certain outpatient medical supplies that are consumable or disposable supplies, including, among other things, gloves, diapers, adhesive bandages, elastic bandages, and gauze* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	All charges

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Care and treatment, including therapy, and room and board in semi-private accommodations are covered up to a combined benefit maximum of 45 days per year when provided in an of the following facilities: • Skilled nursing • Subacute • Inpatient rehabilitation A treatment plan must be approved in advance.	No charge	• 20% coinsurance • Deductible applies
Not covered: • Admission to a skilled nursing, subacute or inpatient rehabilitation facility if the necessary care or therapies can be provided safely in a less intensive setting, including the home or a provider office • Care provided in a facility required to protect you against self-injurious behavior • Custodial Care, even if you receive skilled nursing services or therapies along with custodial care • Leave of Absence - Bed-hold charges incurred when you are on an overnight or weekend pass during an inpatient stay • Non-skilled care received in a residential facility or assisted living facility on a temporary or permanent basis	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
The following hospice care services, provided as part of an established hospice program, are covered when your physician informs us that your condition is terminal and hospice care would be appropriate: • Inpatient hospice care. Short-term inpatient care in a licensed hospice facility is covered when skilled nursing services are required and cannot be provided in other settings. Prior approval of inpatient hospice care is required. • Outpatient hospice care. Outpatient care is covered when intermittent skilled nursing services by a registered nurse or a licensed practical nurse are required or when medical social services under the direction of a physician are required. Outpatient hospice care is any care provided in a setting other than a licensed hospice facility. Hospice Care provided while you are in a hospital or skilled nursing facility is considered outpatient hospice care. • Respite Care. Respite care in a facility setting is covered as outlined in our medical policies.	• No charge for care provided in the home • Any hospice services provided in a facility will be subject to the appropriate facility benefit	• No charge for care provided in the home • Any hospice services provided in a facility will be subject to the appropriate facility benefit

Hospice care - continued on next page

Benefit Description	You pay	
Hospice care (cont.)	**High Option**	**Standard Option**
Not covered: • *Custodial care* • *Private duty nursing*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional emergency ambulance service when medically appropriate.	$150 copayment	• $100 copayment • Deductible applies
Not covered: • *Non-emergency transportation unless you receive prior approval*	*All charges*	*All charges*

Section 5(d) Emergency services/accidents

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.
- The calendar year deductible under the Standard Option is: $350 per person and $700 per family. The calendar year deductible applies to most benefits in this Section.
- There is no calendar year deductible under the High Option.
- 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?

Medical Emergency care and Urgent Care services are Covered under this Certificate. You do not need Prior Approval from your PCP or Priority Health to seek care in a Medical Emergency or when Urgent Care is needed. Prior Approval is not required even when this care is provided by a Non-Participating Provider.

What do do when you need urgent Care:

When you have an illness or injury that needs immediate attention, such as cuts or sprains, but it is not as serious as a medical emergency, call your PCP before you seek any services. Your PCP will help you determine the best place to go for care. If you are out of the service area at that time, your PCP will determine if you can wait for those services and supplies until you could reasonably return to receive them from a Plan provider. If you cannot reach your PCP's office and your illness or injury needs urgent care, go to an urgent care center or hospital emergency room. Present your ID card and be prepared to pay the required copayment or deductible.

Urgent care services received from a non-network provider who is located in our service area are **not** covered.

Urgent care services received from a non-network provider who is located outside of our service area are covered.

If you receive urgent care services from a non-network provider , contact your PCP's office as soon as possible so your PCP can arrange follow-up treatment. Do not return to the urgent care center or emergency room for follow-up care unless it is an urgent situation or medical emergency. Any follow-up care that is provided by a non-network provider must be prior approved by Priority Health in order to be covered.

What to do in case of emergency within or outside our service area:

If you have a medical emergency, seek help immediately. All care needed to treat a medical emergency will be covered. This includes care provided by non-network providers.

If you are confined in a hospital as an inpatient after a medical emergency, you (or someone on your behalf) must let your PCP and Priority Health know about your confinement within 48 hours or as soon as it is reasonably possible. Once your inpatient stay is no longer a medical emergency, Priority Health must approve your continued inpatient stay at any non-network hospital in order for it to be covered. Once your condition has stabilized, Priority Health may require you to be transferred to a Plan facility to continue to be covered.

Following a medical emergency, your PCP can provide or arrange all follow-up care with Plan providers. Follow-up care with non-network providers will only be covered if you receive prior approval from us.

Ambulance Services:

"Ambulance" includes a motor vehicle or aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support, or advanced life support.

In a medical emergency, we will cover EMT and ambulance service to the nearest medical facility that can provide medical emergency care.

We will cover ambulance transfers between facilities that we approve in advance. Any other non-emergent transportation is not covered unless approved in advance by us.

Benefit Description	You pay	
Emergency/Urgent Care within our service area	**High Option**	**Standard Option**
• Urgent care center services	$75 copayment	$75 copayment Deductible does *not* apply
• Emergency room services	$150 copayment, waived if admitted	$100 copayment, waived if admitted Deductible applies
Not covered: • *Elective care* • *Non-emergency care* • *Urgent care services provided by a non-network provider within our service area*	*All charges.*	*All charges.*
Emergency/Urgent Care outside our service area	**High Option**	**Standard Option**
• Urgent care center services	$75 copayment	$75 copayment Deductible does *not* apply
• Emergency room services	$150 copayment, waived if admited	$100 copayment, waived if admitted Deductible applies
Not covered: • *Elective care* • *Non-emergency care*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional emergency ambulance service when medically appropriate.	$150 copayment	$100 copayment Deductible applies
Not covered: • *Non-emergency transportation unless you receive prior approval*	*All charges*	*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/clinically necessary.
- Plan physicians must provide or arrange for all of your care.
- Except in an emergency, prior approval is required for inpatient mental health and substance abuse services.
- The contract year deductible under the Standard Option is: $350 per person and $700 per family. The calendar year deductible applies to most benefits in this Section.
- There is no contract year deductible under the High Option.
- 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

Mental Health Services

Mental health services are available in a variety of settings. You may be treated as an inpatient or as an outpatient depending on your particular condition. Services will generally be provided in the least restrictive place that will allow for the best results for any particular condition. If you don't know where to go for treatment, call our Behavioral Health Department at 616 464-8500 or 800 673-8043 to speak with a trained clinician who can assist you.

Substance Abuse Services

Substance abuse services are also covered in a variety of settings. You may be treated in an inpatient or outpatient setting, depending on your particular condition. Services will generally be provided in the least restrictive place that will allow for the best results for any particular condition. If you don't know what the most appropriate treatment setting is for your condition, call our Behavioral Health Department at 616 464-8500 or 800 673-8043 for assistance. Priority Health follows the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

Outpatient substance abuse services do not require referral from your PCP or us. Inpatient substance abuse services (including residential treatment and partial hospitalization) require prior approval from our Behavioral Health Department, except in a medical emergency.

Benefit Description	You pay	
Mental health services	**High Option**	**Standard Option**
This plan covers evaluation, consultation and treatment necessary to determine a diagnosis and treatment plan for both acute and chronic mental health conditions. Both crisis intervention and Medically/clinically necessary treatment of ongoing and/or chronic mental health conditions are covered. Covered services must be: 1. Provided by licensed behavioral health professionals acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or family therapists; 2. Provided in licensed behavioral health treatment facilities; and	Your cost-sharing responsibilities are no greater than for other illnesses or injury covered under this Plan • $10 copayment for outpatient services • No charge for inpatient services	Your cost-sharing responsibilities are no greater than for other illnesses or injury covered under this Plan • $15 copayment for outpatient services • 20% coinsurance for inpatient services • Deductible applies

Mental health services - continued on next page

Benefit Description	You pay	
Mental health services (cont.)	**High Option**	**Standard Option**
3. Medically/clinically necessary and based on evidence-based standards for treatment of your condition. Mental health services are available in a variety of settings. You may be treated as an inpatient or as an outpatient depending on your particular condition. Services will generally be provided in the least restrictive place that will allow for the best results for any particular condition. If you don't know where to go for treatment, call our Behavioral Health Department at 616 464-8500 or 800 673-8043 to speak with a trained clinician who can assist you. Covered treatment settings include: • Acute Inpatient Hospitalization • Residential Treatment • Partial Hospitalization • Intensive Outpatient Treatment • Outpatient Treatment Mental health inpatient care includes residential treatment facility and partial hospitalization care. Mental health outpatient care includes medication management visits.	Your cost-sharing responsibilities are no greater than for other illnesses or injury covered under this Plan • $10 copayment for outpatient services • No charge for inpatient services	Your cost-sharing responsibilities are no greater than for other illnesses or injury covered under this Plan • $15 copayment for outpatient services • 20% coinsurance for inpatient services • Deductible applies
Certain conditions have unique coverage limitations as stated below. Treatment for medical complications related to these conditions, including but not limited to neuropsychological testing, when appropriate, is covered. • Eating disorders, and feeding disorders of infancy or childhood, are covered at all levels of care described above based on our medical policies. • Attention deficit hyperactivity disorders are Covered for initial evaluation, and follow-up psychiatric medication management. Outpatient behavioral therapy is covered for children age 12 and under. • Personality disorders are covered only for specific psychological testing to clarify the diagnosis. • Organic brain disorders are covered for initial evaluation to clarify the diagnosis and for follow-up psychiatric medication management. Inpatient services for members with organic brain disorders, such as closed head Injuries, Alzheimer's and other forms of dementia, are covered based on our medical policies.	• $10 copayment for outpatient services • No charge for inpatient services	• $15 copayment for outpatient services • 20% coinsurance for inpatient services • Deductible applies

Mental health services - continued on next page

Benefit Description	You pay	
Mental health services (cont.)	**High Option**	**Standard Option**
• Autistic Disorder, including Asperger's Disorder and Unspecified Pervasive Developmental Disorder not otherwise specified, are covered for evidence based treatment services. (See the **Autism Spectrum Disorder Treatment** section for covered services and limitations.) • Intellectual Disabilities are covered for initial evaluation and follow up psychiatric medication management.	• $10 copayment for outpatient services • No charge for inpatient services	• $15 copayment for outpatient services • 20% coinsurance for inpatient services • Deductible applies
Substance abuse services	**High Option**	**Standard Option**
When medically/clinically necessary, covered substance abuse services, include but are not limited to: • counseling • medical testing • diagnostic evaluation • detoxification services Covered treatment includes: • Inpatient Detoxification • Medically Monitored Intensive Inpatient Treatment • Residential Treatment • Partial Hospitalization • Intensive Outpatient Programs • Outpatient Treatment • Outpatient/Ambulatory Detoxification	• $10 copayment for outpatient services • No charge for inpatient services	• $15 copayment for outpatient services • 20% coinsurance inpatient services • Deductible applies
Not covered	**High Option**	**Standard Option**
Mental health services that are not covered include: • *Care provided in a non-licensed residential or institutional facility, such as the costs of living and being cared for in transitional living centers, foster care facilities, therapeutic boarding schools, wilderness therapy programs, custodial care or halfway houses* • *Counseling and other services for antisocial personality, insomnia and other non-medical sleep disorders, marital and relationship enhancement, and religious oriented counseling provided by a religious counselor who is not a Plan provider* • *Experimental/investigational or unproven treatments and services* • *Scholastic/educational testing*	*All charges*	*All charges*

Not covered - continued on next page

Benefit Description	You pay	
Not covered (cont.)	**High Option**	**Standard Option**
Substance abuse services that are not covered include: • *Non-skilled care received in a home or facility on a temporary or permanent basis* • *Experimental/investigational or unproven treatments and services* *Note: 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.*	*All charges*	*All charges*

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- 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.

There 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 Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication
- **Using our Approved Drug List or "Formulary"** - Coverage is based on the usage of our Approved Drug List. Drugs are added to, or removed from, the Approved Drug List on a regular basis. Some drugs require prior approval. A prescriber may submit a prior approval request. These requests will be reviewed by Priority Health clinical staff on a case by case basis, and coverage may be approved upon review by us.

We expect our Approved Drug List will meet all members' prescription drug needs. But, if a Plan physician prescribes a non-formulary drug, that drug may be covered, if approved upon review by us. Priority Health will provide notice of its determination regarding an exception for a non-formulary drug within 24 hours of receiving all information necessary to make the determination. We will cover outpatient prescription drugs dispensed by a non Plan pharmacy during a medical emergency or urgent care situation.

- **These are the dispensing limitations.** You may obtain up to a 31-day supply of medication at a retail Participating Pharmacy. A lesser-day supply may apply based on pre-packaged products. For example, based on dosing, an asthma inhaler may last for 25 days. In this instance, only one inhaler would be dispensed, since two inhalers would exceed the 31-day supply limit. Insulin is the exception to this rule and the quantity is rounded up or down based on dosing. For example, if a member needs one and one half vials for a 31-day supply, we will round up to two vials.
- **Mail service program.** Medications needed on a long-term basis may be delivered postage paid, directly to your home through our mail service prescription drug program. A 90-day supply of medication is available through this service for two Copayments except in the case of Specialty Drugs or drugs that are prohibited by law (such as Accutane), or if your Group has purchased a different benefit design. Information on the prescription drug mail order program is available from our Customer Service Department or on our website at priorityhealth.com.
- **Specialty Drugs.** Certain Specialty Drugs requiring administration by a Health Professional in a medical office, home or outpatient facility are Covered under the medical plan instead of this Prescription Drug Rider.
- **Why use Generic Drugs.** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than a name-brand drug.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
Covered outpatient prescription drugs include some or all of the following: • Federal legend drugs medicinal substances available only through prescription. • State-restricted drugs medicinal substances which, according to state law, may only be dispensed by prescription. • Compounded medications medicinal substances compounded by the pharmacist which have at least one ingredient that is federal legend or state-restricted in a therapeutic amount. • Injectable insulin and disposable syringes and needles for administration of injectable insulin; nonexperimental medication for controlling blood sugar and medication used in the treatment of ailments, infections or medical conditions of the foot, ankle or nails associated with diabetes. (Note: Diabetic supplies such as syringes, needles, lancets, and blood glucose test strips, can be purchased at a Plan pharmacy and your applicable prescription drug copayment will apply. These supplies can also be purchased at a participating Durable Medical Equipment (DME) provider and your DME copayment will apply.	**Retail Prescriptions:** $10 copayment per generic prescription $40 copayment for preferred-brand presciption $60 copayment for non-preferred brand prescription 20% coinsurance for preferred specialty drugs - The maximum co-pay for preferred specialty drugs is $100 per fill 20% coinsurance for preferred specialty drugs - The maximum co-pay for non-preferred specialty drugs is $200 per fill Deductible does not apply to outpatient prescription drugs **Mail Order:** Two applicable copayments for a 90 day supply of generic, preferred-brand or non-preferred brand prescription drugs	**Retail Prescriptions:** $10 copayment per generic prescription $45 copayment for preferred-brand presciption $90 copayment for non-preferred brand prescription 20% coinsurance for preferred specialty drugs - The maximum co-pay for preferred specialty drugs is $150 per fill 20% coinsurance for preferred specialty drugs - The maximum co-pay for non-preferred specialty drugs is $300 per fill Deductible does not apply to outpatient prescription drugs **Mail Order:** Two applicable copayments for a 90 day supply of generic, preferred-brand or non-preferred brand prescription drugs
Women's prescribed contraceptive drugs and devices, such as birth control pills, diaphragms, IUD's and implantable contraceptive devices. Brand name oral and injectable contraceptive drugs are subject to the applicable Brand Name Drugs Copayment described below unless otherwise approved by Priority Health as Medically/Clinically Necessary. All other prescribed women's contraceptive drugs and devices are Covered under preventive health care services at no cost share to the Member. Note: Over-the-counter contraceptives drugs and devices approved by the FDA require a written prescription by an approved provider.	No charge	No charge
Drugs used for the purpose of treating infertility	50% coinsurance	50% coinsurance

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Not Covered: • Drugs which do not, by federal or state law, require a prescription order (over-the-counter (OTC) drugs) or prescribed drugs for which there is an OTC equivalent available without a prescription order (such as Lotrimin). We may elect to include certain OTC drugs on the Approved Drug List, based on recommendations made by our Pharmacy and Therapeutics Committee. OTC drugs listed in Preventive Health Care Guidelines are Covered. • Schedule V controlled substances available without a prescription order. • Cosmetics or any drugs used for cosmetic purposes (such as, for example, drugs for the treatment of wrinkles, hair loss, and health or beauty aids). • Drugs for the treatment of sexual dysfunction, regardless of age, gender or health status (but not including drugs for the treatment of infertility). • Men's contraceptives. • Multivitamins (except prenatal vitamins); nutritional supplements (except when these are the only means of nutrition); and drugs used for the purpose of weight reduction, such as appetite suppressants. • Any medication prescribed in a manner other than in accordance with our procedures. • Replacement of lost or damaged prescriptions. • Drugs not approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations. • Refills in excess of the amount specified by the prescriber, and any refill dispensed after one year from the order of the prescriber. Specialty drugs in excess of a 31-day supply are not covered even if specified by the prescriber.	*All charges.*	*All charges.*

Section 5(g) Dental 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
- 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.
- The calendar year deductible under the Standard Option is: $350 per person and $700 per family. The calendar year deductible applies to most benefits in this Section.
- There is no calendar year deductible under the High Option.
- 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**	**Standard 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.	$30 copayment	• $30 copayment • Deductible does *not* apply
Dental Benefits	**High Option**	**Standard Option**
We have no other dental benefits		

Section 5(h) Special features

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 termsin 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 coorporate 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 expressely provided in this 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 claim process (see Section 8).

HealthbyChoice Motivations℠	Take steps to be your healthiest and receive a $25 gift card. How to earn the reward 1. Complete a free health assessment Log in to your member account at prioirtyhealth.com/member and take the online health assessment to identify potential health issues before they occur and receive personalized steps for improving your health. 2. Visit your doctor Have your doctor complete your HealthbyChoice Motivations form to confirm you meet the following health indicators: • Tobacco use – must be tobacco free • Body mass index (BMI) – must be under 30 • Blood pressure – must be 140/90 or 140/80, based on risk factor* • Cholesterol – LDL must be under 160 or under 100, based on risk factor* • Blood sugar – HbA1c must be lower than 8% for employees with diabetes, or fasting blood sugar lower than 126 for members with heart disease In order to receive a $25 gift card, these requirements must be completed within the first 90 days of your plan effective date. If you fail to meet one or more of the criteria you can still pass by completing a Priority Health coaching program.

Virtual Visits	See a doctor 24/7 from home Get treated online or over the phone If you're sick and your doctor isn't available, you don't need to go to the urgent care or emergency room. All Priority Health members can see a doctor 24 hours a day, seven days a week online or over the phone with MDLIVETM. Remember! Your primary care doctor is always the first person you should call when you're sick. They know you and your health, so they're the best place to go for routine care, preventive checkups and chronic condition management. They may also have options for you to get care quickly, even when their office is closed. Get care anytime, anywhere with virtual visits Virtual visits are a great option if you're: Considering the ER or urgent care for a nonemergency In need of care outside your doctor's normal business hours, including nights, weekends or holidays or traveling. What do virtual visits treat? Virtual visits treat non-emergency conditions, such as: Cold and flu Fever Respiratory infections Sinus infections Sore throats See more about virtual visits on priorityhealth.com
Assist America: Global emergency help	Assist America provides global emergency medical services for you and your dependents. If someone becomes ill or injured while traveling more than 100 miles from home or is in a foreign country, Assist America provides support with medical referrals, monitoring, evacuation, repatriation and much more. **Assist America features & advantages** - Free to FEHB Priority Health members - Covers the costs of all services related to getting quality emergency medical care while traveling, such as medical referrals, critical care monitoring, emergency evacuation and other support measures - Note: Once a qualified doctor or hospital begins care, all treatment costs are subject to the coverage rules of your plan - Available everywhere in the world, regardless of geography or political climate - Access to multilingual, medically-trained employees anytime, anywhere - Pre-trip information including visa requirements, immunization regulations and security advisories - No financial cap on services - No exclusions for pre-existing conditions or extreme sports/hazardous hobbies **Print a reference card to carry when you travel** Get help when you need it by calling Assist America 24 hours a day, 7 days a week, using the contact information and Priority Health reference number on your card. Assist America contacts: 800.872.1414 (inside the US) 609.986.1234 (outside the US) Email: medservices@assistamerica.com Mobile app: Available for Android and iPhone devices Website: assistamerica.com

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/clinically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition**. **For 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 that are not medically/clinically 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 related to sex transformations;

•Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or

•Services, drugs, or supplies you receive without charge while in active military service.

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, deductible, or co-insurance if applicable.

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 and hospital 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-92 form. For claims questions and assistance, please contact us at 800 446-5674 or visit our website at priorityhealth.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the HCFA-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:

Priority Health
P.O. Box 232
Grand Rapids, MI 49501-0232

Prescription drugs and Other supplies or services

If you need to submit a prescription claim or claim for any other covered supply or service, you may follow the same steps outlined above for submitting medical and hospital benefit claims.

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.

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.

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 be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, *please visit priorityhealth.com/federal.*

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (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 admissions.

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 Priority Health Customer Service Department, MS 1105, P.O. Box 269, Grand Rapids, MI 49501-0269, or by calling 800 446-5674.

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 decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions 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.Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

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: Priority Health, Customer Service Department, MS 1105, Grand Rapids, MI 49501-0269, or use our secure email in the member center on our website at priorityhealth.com

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.

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 30 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.

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

3

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.

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 sue, 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 or life threatening condition (one that may cause permanent loss of bodily functions 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 800 446-5674. 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's Health Insurance at (202) 606-3818 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 Programsif 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 a 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 a 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

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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, 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 does not cover these costs.
- 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) for more information.
- 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 do 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 important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this 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 Social Security Associated 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 are 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.

Claims process when you have the Original Medicare Plan -- You will probably 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. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800 446-5674 or see our website at priorityhealth.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

You can find more information about how our plan coordinates benefits with Medicare at priorityhealth.com.

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 our Medicare Advantage plan: You may enroll in one of the Medicare Advantage plans offered by Priority Health and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even if you are out of the Medicare Advantage plan's network and/or service area (if you use the providers who participate with this Plan). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in our 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.

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 plan 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

Applied Behavior Analysis (ABA)

Outpatient treatment involving behavioral modification techniques in which reinforcement, either positive or negative, is used to encourage or reduce certain behaviors. The treatment is delivered in a highly structured and intensive program with one-to-one instruction by a certified therapist.

Autism Spectrum Disorder

A developmental disorder of brain function which is classified as one of the pervasive developmental disorders. For purposes of this Plan, Autism Spectrum Disorder is treatment coverage for diagnosis of Autistic Disorder, Unspecified Pervasive Developmental Disorder, and Other Pervasive Developmental Disorders (Asperger's Disorder, Rhett's Disorder).

Brochure

The legal document that describes the rights and responsibilities of both you and Priority Health according to our contract (CS 2944) with the United States Office of Personnel Management, as authorized by the Federal Employee Health Benefits law. It includes this document and any amendments and attachments to this document.

Clinical trials cost categories

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.

- 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 are generally covered by the clinical trials. This Plan does not cover these costs.

Coinsurance

The percentage of the cost of a covered service that you must pay directly to a provider at the time you receive the covered services and supplies. This percentage may also be called a copayment.

Complications of a pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Examples of such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, hyperemesis gravidarum, pre-eclampsia, and similar medical and surgical conditions of comparable severity. It also includes conditions such as termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. It does not include medically/clinically necessary or emergency cesarean section, false labor, occasional spotting, physician-prescribed rest during a pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Contract year

The period of time that starts on the day you first enroll in coverage under this Plan and ends on December 31 of the same year.

Copayments

The amount you must pay directly to a provider for a covered service at the time you receive the services and supplies. A copayment may be either a flat dollar amount or a percentage, such as $20.00 for a PCP office visit or 20% of the cost of an outpatient surgery. A percentage copayment may also be called coinsurance.

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (such as deductible, coinsurance, and copayments) for covered services.
Covered or eligible dependent	An individual eligible to enroll in this plan because he or she is the enrollee's legally married spouse or dependent child under age 26.
Covered services, coverage, cover or covered	Services and supplies for which this plan will pay all or part of the costs, as listed in this brochure, so long as you are an eligible member. The services or supplies must be preventive or medically/clinically necessary and not otherwise excluded by this Plan. When we say we will "cover" a service or supply, that means we will treat the service or supply as a covered service.
Custodial care	Care you receive if, in our opinion, you have reached the maximum level of mental and/or physical function and you will not improve significantly more. This type of care includes room and board, therapies, nursing care, home health aides and personal care designed to help you in the activities of daily living and home care and adult day care that you receive, or could receive, from a member of your family.
Deductible	An amount that you must pay before Priority Health will pay for certain covered services under this Plan. For example, if your deductible is $1,000, we won't pay anything until you've paid $1,000 for covered services that are subject to the deductible.
Disputed claims process	The process you may follow if you don not agree with our decision regarding a claim or prior approval decision. A more detailed explanation of the disputed claims process is available in Section 8 of this brochure.
Durable medical equipment (DME)	Information about DME is available in Section 5(a) of this brochure.
Enrollee	A Federal employee eligible to enroll in this plan.
Health professional	An individual licensed, certified or authorized under state law to practice a health profession.
Home health care	Information about home health care is available in Section 5(a) of this brochure.
Hospice care	Services for the terminally ill and their families including pain management and other supportive services.
Hospital	An appropriately licensed acute care institution (including a longterm acute care facility) that provides inpatient and outpatient medical care and treatment for ill and injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of physicians and with 24 hour-a-day nursing and physician service.
Hospital inpatient care	Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for hospital observation care may be considered outpatient care.
Hospital observation care	Short term treatment and monitoring that is provided on an outpatient basis. This type of care is commonly provided after you visit an emergency room to allow health professionals to determine if you can be discharged or if you need to be admitted as an inpatient for additional treatment. Hospital observation care is typically limited to 24-48 hours. Even when you are required to stay at the hospital overnight, if you are receiving observation care, you have not been admitted as an inpatient. See Section 5(a) of this brochure for information about your hospital outpatient care benefit.
Hospital outpatient care	Care in a hospital that usually doesn't require an overnight stay.
Ill or illness	A sickness or a disease, including congenital defects or birth abnormalities.
Injury or injured	Accidental bodily harm.

Intellectual disabilities	Disabilities characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills originating before the age of 18.
Medicaid	Title XIX of the Social Security Act, as amended.
Medical Director	A Michigan-licensed physician, employed by Priority Health, who oversees the plan's medical delivery system.
Medical emergency	The sudden onset of an illness or injury, symptom or condition serious enough that not seeking immediate medical attention could reasonably be expected to result in serious harm to your health, serious jeopardy to a pregnancy, or death.
Medically/clinically necessary	The services or supplies needed to diagnose or treat your physical or mental condition. Whether services or supplies are medically/clinically necessary is determined in accordance with Priority Health's medical and behavioral health policies or adopted criteria that have been approved by community physicians and other providers. The determination is made by Priority Health's medical director, or anyone acting at the medical director's direction, in consultation with other physicians. medical/clinical necessity of mental health and substance abuse services is determined by our Behavioral Health Department. In order to be considered medically/clinically necessary, the services or supplies must be widely accepted as effective, appropriate, and essential, based upon nationally accepted evidence-based standards.
Medicare	Title XVIII of the Social Security Act, as amended.
Member	A person enrolled with us as an enrollee or as a covered/eligible dependent.
Mental Health	Acute Inpatient Hospitalization. This is the most intensive level of care. Prior approval from our Behavioral Health department is required for inpatient services except in a medical emergency. Upon discharge, you will be referred to a less intensive level of care. Residential Treatment. This is 24-hour confinement in a subacute residential setting (as defined above) licensed by the state with structured, licensed health care professionals accessible 24 hours a day and 7 days a week. A licensed foster-care facility serving as your residence is not Covered and does not meet the definition of "Residential Treatment". Prior approval from our Behavioral Health department is required for residential treatment services. Partial Hospitalization. This is a non-residential level of service that is similar in intensity to acute inpatient hospitalization. You are generally in treatment for more than four hours but less than eight hours daily. Prior approval from our Behavioral Health department is required for partial hospitalization services. Intensive Outpatient Treatment. This is outpatient treatment that is provided with more frequency and intensity than routine outpatient treatment. You are generally in treatment for up to four hours per day, and up to five days per week. You may be treated individually, as a family or in a group. Outpatient Treatment. This is the least intensive, and most common, type of service. It is provided in an office setting, generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day by a licensed behavioral health professional
Newborn	A child 30 days old or younger.
Non-covered or excluded services	Health care services that this plan does not pay for or cover.

Non-participating or non-Plan provider	The physicians, health professionals, hospitals and other providers and facilities that have not contracted with Priority Health to provide covered services to members. Non-participating or non-Plan providers are not listed in the Priority Health Provider Directory. covered services and supplies you seek from a non-Plan provider are not covered.
Open season	An annual period during which you and your eligible dependents may enroll in this Plan or, if you are already enrolled, during which you may change your coverage elections.
Out-of-area services	Those services and supplies provided outside our service area.
Out-of-pocket limit or maximum	The maximum amount of deductibles, copayments and coinsurance you will pay for covered services in a contract year. Once you reach this overall maximum, covered services will be covered at 100% with no cost to you unless we tell you otherwise in this brochure. This protects you against catastrophic costs. Some costs do not count toward t his protection.
Physician	A licensed medical doctor (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) or surgeon.
Plan or participating provider	The physicians, health professionals, hospitals and other facilities that have contracted with Priority Health to provide covered services. The Providers that make up our network are considered Plan or participating providers and are listed in our Provider Directory.
Post-service claim	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.
Pre-service claim	Those claims (1) that require prior approval or a referral and (2) where failure to obtain prior approval or a referral results in a reduction of benefits.
Premium	The total amount paid to us for coverage under this plan, including contributions from your employer and you.
Prescription drug coverage	Prescription drug coverage you are entitled to receive under this Plan. More information about drugs covered under your Priority Health plan is available in Section 5(f).
Preventive Health Care Guidelines	A list of immunizations, screenings, lab tests and other services that we cover to help you maintain optimum health and prevent unnecessary injury, illness or disability. Our guidelines are developed by health professionals who are Plan providers or employed by us, and are based on federal requirements for coverage of preventive health care services contained in Section 1001 of the Patient Protection and Affordable Care Act (PPACA), available at www.healthcare.gov.
Primary Care Provider ("PCP")	The Plan provider you select as explained in Section 3. Your PCP provides, arranges and coordinates all aspects of your health care to help you receive the right care, in the right place, at the right time.
Prior approval	A decision made by Priority Health as to whether a service or supply is covered or not covered under the plan. It may also include a decision to partially cover a service. See Section 3 for more information about when and how to obtain prior approval.
Provider	A licensed health professional or facility that provides health care services.
Provider Directory	The names and locations of Plan providers who comprise our network. Also included, among other things, are whether the provider is accepting new members and quality and performance information. You may call our Customer Service department to obtain a list of providers in your area, or you can go to the Member Center on our website at www.priorityhealth.com.

Residential treatment	Treatment provided in a state-licensed subacute facility with structured, licensed health professionals. This treatment must be medically-monitored and must include access to the following: (i) medical services twenty-four (24) hours per day, seven (7) days per week; (ii) nursing services twenty-four (24) hours per day, seven (7) days per week; and (iii) physician on call availability for emergency twenty-four (24) hours per day, seven (7) days per week. Services provided in a licensed foster-care facility serving as an individual's residence are not covered and do not meet the definition of "Residential Treatment."
Service area	A geographical area, made up of counties or parts of counties, where we have been authorized by the State of Michigan to sell and market our health plans and where the majority of our participating providers are located. We publish precise service area boundaries that you can find on our website www.priorityhealth.com or receive from our Customer Service Department.
Skilled nursing services	Information about skilled nursing services is available in Section 5(c) of this brochure.
Specialist or specialist provider	A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
Specialty drug	Drugs listed on our approved drug list that meet certain criteria, such as drugs or drug classes whose cost on a per-month or per-dose basis exceed a threshold established by the Centers for Medicare and Medicaid Services; drugs that require special handling or administration; drugs that have limited distribution; or drugs in selected therapeutic categories.
Specialty pharmacy	A pharmacy that specializes in the handling, distribution, and patient management of specialty drugs.
Substance Abuse	Inpatient Detoxification. These are detoxification services that are provided while you are an inpatient in a hospital or subacute unit. When provided in a medical setting, services are managed jointly by our Behavioral Health and Health Management Departments. Medically Monitored Intensive Inpatient Treatment. Following full or partial recovery from acute detoxification symptoms, this type of care is provided at an inpatient facility or subacute unit. Residential Treatment. This is 24-hour confinement in a subacute residential setting (as defined above) licensed by the state with structured, licensed health care professionals accessible 24 hours a day and 7 days a week. A licensed foster-care facility serving as your residence is not covered and does not meet the definition of "residential treatment". Prior approval from our Behavioral Health department is required for residential treatment services. Partial Hospitalization. This is an intensive, non-residential level of service provided in a structured setting, similar in intensity to inpatient treatment. You are generally in treatment for more than four hours but generally less than eight hours daily. Intensive Outpatient Programs. These are outpatient services provided by a variety of health professionals at a frequency of up to four hours daily, and up to five days per week. Outpatient Treatment. This is the least intensive level of service. It is provided in an office setting generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day. Outpatient/Ambulatory Detoxification. These detoxification services may be provided on an outpatient basis within a structured program when the consequences of withdrawal are non-life-threatening. These services are covered under your medical benefits.

Treatment Plan	A method of using objectives and measurable goals to monitor progress and improvement in an individual's care for Autism Spectrum Disorder. The plan is developed under the supervision of a Board Certified Behavior Analyst (BCBA).
Urgent care or urgent care center	Care provided at an urgent care center, instead of a hospital emergency room, when you need immediate care to treat a non-life threatening illness or injury to limit severity and prevent complications. 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 the care or treatment that is the 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 616 942-1221 or 800 446-5674. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
We, us or our	Priority Health.
You, your or yourself	The member, whether enrolled with Priority Health as an enrollee or covered/eligible dependent.

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 eligible 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. 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 reimbursement 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 dependant 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 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 Empolyees 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 Service 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 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 atwww.opm.gov/healthcare-insurance/dental-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-(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. You must apply to know if you will be approved for enrollment. 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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Summary of benefits for the High Option of Priority Health - 2015

- **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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		26-39
Diagnostic and treatment services provided in the office	Office visit copay: $10 copayment primary care; $30 copayment specialist	25
Services provided by a hospital:		49-52
• Inpatient	No charge	49-50
• Outpatient	Surgical Center: No charge	50
Emergency benefits:		53-54
• In-area	$150 copayment per visit, waived if admitted	54
• Out-of-area	$150 copayment per visit, waived if admitted	54
Mental health and substance abuse treatment:	Regular cost-sharing	55-58
Prescription drugs:	Retail: $10 copayment per generic prescription, $40 copayment per brand prescription, $60 copayment per non-preferred brand 20% coinsurance for preferred specialty drugs - The maximum co-pay for preferred specialty drugs is $100 per fill. 20% coinsurance for preferred specialty drugs - The maximum co-pay for non-preferred specialty drugs is $200 per fill. Mail Order: 2x copayment for 90 day supply	59-61
Dental care:	No Coverage	62
Vision care:	No coverage for routine eye exam	None
Protection against catastrophic costs (your out-of-pocket maximum)**:**	$6,600 Single $13,200 Family Some costs do not count toward this protection.	22

Summary of benefits for the Standard Option of Priority Health - 2015

- **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.
- Asterisk (*) means the item is subject to the $350 single or $700 family calendar year deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		26-39
Diagnostic and treatment services provided in the office	Office visit copay: $15 copayment primary care; $30 copayment specialist	25
Services provided by a hospital:		49-52
• Inpatient*	20% coinsurance	49-50
• Outpatient*	20% coinsurance	50
Emergency benefits:		53
• In-area*	$100 per visit, waived if admitted	54
• Out-of-area*	$100 per visit, waived if admitted	54
Mental health and substance abuse treatment:	Regular cost-sharing	55-58
Prescription drugs:	Retail: $10 copayment per generic prescription, $45 copayment per brand prescription, $90 copayment for non-preferred prescripton 20% coinsurance for preferred specialty drugs - The maximum co-pay for preferred specialty drugs is $150 per fill. 20% coinsurance for preferred specialty drugs - The maximum co-pay for non-preferred specialty drugs is $300 per fill. Deductible does not apply to outpatient prescription drugs. Mail Order: 2x copayment for 90 day supply	59-61
Dental care:	No coverage	62
Vision care:	No coverage for routine eye exam	None
Protection against catastrophic costs (your out-of-pocket maximum)**:**	$6,600 Single $13,200 Family Some costs do not count toward this protection	22

Notes

2015 Rate Information

For 2015 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.