Priority Health

priorityhealth.com/fehb

Customer Service 800-446-5674

PriorityHealth®

2023

A Health Maintenance Organization (High, Standard and Value Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. This plan is accredited. See page 13.

Serving the counties in 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 15 for service area.

IMPORTANT
- Rates: Back Cover
- Changes for 2023: Page 16
- Summary of Benefits: Page 103

Enrollment codes for this Plan:

LE1 High Option - Self Only
LE3 High Option - Self Plus One
LE2 High Option - Self and Family

LE4 Standard Option - Self Only
LE6 Standard Option - Self Plus One
LE5 Standard Option - Self and Family

Y41 Value Option - Self Only
Y43 Value Option - Self Plus One
Y42 Value Option - Self and Family

FEHB
Federal Employees
Health Benefits Program

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 your FEHB plan 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 is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent 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 800-772-1213, (TTY: 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 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of Priority Health under contract (CS 2944) between Priority Health and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 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 verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or 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, 2023 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2023 and changes are summarized on page 16. Rates are shown at the end of this brochure.

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 and each covered 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 healthcare 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 phone or to people you do not know, except to your healthcare 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 you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 800 446-5674 and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE

877-499-7295

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

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

You can also write to:

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

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless they are disabled and incapable of self support prior to age 26)
- A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- 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 (TCC).
- 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.

Discrimination is Against the Law

Priority Health complies with all applicable Federal civil rights laws, including both Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at: Office of Personnel Management Healthcare and Insurance Federal Employee Insurance Operations, Attention: Assistant Director, FEIO, 1900 E Street NW, Suite 3400 S, Washington, D.C. 20415-3610.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of our own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medication 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

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

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.

- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.

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

- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. Priority Health has a medical policy that follows the basic philosophy that payment will not be made for medical errors, but recognizes that many variables can impact payment determination in any specific case.

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. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

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

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

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, give you other plans' brochures 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 do not 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, disability leave, pensions, etc you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

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

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee, and one or more eligible family members. Family members include 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 Plus One or 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 Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self Plus 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your carrier to add a family member when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a family member if you currently have a Self Only plan.

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, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: 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
Coverage: 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
Coverage: 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
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2023 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2022 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 additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **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). 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, or if you are a covered child and you turn 26.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. 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 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.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert**.** You must contact us in writing within 31 days after you receive this notice**.** However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-446-4674 or visit our website at www.priorityhealth.com/fehb.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA'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). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Priority Health holds the following accreditations: NCQA. To learn more about this plan's accreditation(s), please visit the following website:

- National Committee for Quality Assurance (www.ncqa.org)

We require you to see specific physicians, hospitals, and other providers that contract with us. These participating Plan providers coordinate your healthcare services. We are solely responsible for the selection of these providers in your area. The provider directory is available on our website at *priorityhealth.com* or by calling our Customer Service Department. We give you a choice of enrollment in a High Option, Standard Option or Value 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. This plan covers services that are medically/clinically necessary as explained in this brochure and according to Priority Health's medical and behavioral health policies.

When you receive services from participating 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 evaluation and management services at a Retail Health Clinic or 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. Our Value Option offers benefits with higher out-of-pocket expenses, including the highest deductible, but at the lowest premium cost to you. All options provide access to Priority Health's high quality service. You can reduce your out-of-pocket expenses under the options even further, including completely eliminating the Standard and Value Option deductible, if you are eligible for and enrolled in Medicare Part B in addition to your coverage with Priority Health.

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. You may also receive covered services from any retail service center located within the United States without referral.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide most of the benefits in this brochure. These participating Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

This brochure also covers evaluation and management services obtained from any Retail Health Clinic located within the United States. We may not be contracted with all providers at these types of facilities. However, you will still only be responsible for deductible, copayments or coinsurance even if you receive covered services from a non-participating Plan provider at a Retail Health Clinic.

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 participating Plan provider.

Annual deductible

For the High Option, there is no deductible. For the Standard Option, there is a $350 annual deductible Self Only and $700 annual deductible for Self Plus One and Self and Family. For the Value Option, there is a $1,500 annual deductible Self Only and $3,000 annual deductible Self Plus One and Self and Family that must be met before plan benefits are paid for care other than preventive care services. If you are enrolled in Medicare Part B, your Standard and Value Option deductible will be waived.

Catastrophic Protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $7,350 Self Only enrollment, and $14,700 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

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:

- Priority Health has been in existence for over 30 years
- Profit Status
- 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

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Priority Health at www.priorityhealth.com. You can also contact us to request that we mail a copy to you.

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

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website Priority Health at www.priorityhealth.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

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 at www.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 *www.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 in this plan, you must live or work in our service area. This is where our providers practice. Our service area is the Lower Peninsula of Michigan. Counties include: Alcona, Allegan, Alpena, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Cass, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Ionia, Iosco, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Livingston, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Montcalm, Monroe, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, St. Joseph, Tuscola, VanBuren, Washtenaw, Wayne, Wexford.

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 care provided in a Retail Health Clinic located within the United States, emergency care and urgent care benefits. We will not pay for any other healthcare 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.

Covered dependent children residing outside the service area within the United States are covered by the Cigna network at the in-network benefit level.

If you have dependent children living outside the service area but within the United States, services are covered at the out of network dependent child benefit when services are provided by a non-participating provider. Contact us for details.

Section 2. Changes for 2023

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

Program-wide changes

- There are no program-wide changes for 2023.

High Option Changes

- Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. See page 108.
- Infertility services:

  We are adding fertility preservation services to help mitigate the risk of infertility in members undergoing medical therapies prescribed by their providers and likely to result in Iatrogenic Infertility. Prior authorization is not required. See pages 38-39.

  We are adding IVF (in vitro fertilization) as a covered service. See pages 38-39.

Standard Option Changes

- Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. See page 108.
- Infertility services:

  We are adding fertility preservation services to help mitigate the risk of infertility in members undergoing medical therapies prescribed by their providers and likely to result in Iatrogenic Infertility. Prior authorization is not required. See pages 38-39.

  We are adding IVF (in vitro fertilization) as a covered service. See pages 38-39.

Value Option Changes

- Your share of the premium remains the same. See page 108.
- Infertility services:

  We are adding fertility preservation services to help mitigate the risk of infertility in members undergoing medical therapies prescribed by their providers and likely to result in Iatrogenic Infertility. Prior authorization is not required. See pages 38-39.

  We are adding IVF (in vitro fertilization) as a covered service. See pages 38-39.

Wellness Benefit

- The wellness benefit incentive is now only available under the Non-FEHB Benefits section. See page 82.

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 participating Plan provider, or fill a prescription at a participating Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800 446-5674 or write to us at: Priority Health, 1231 East Beltline NE, Grand Rapids, MI 49525. You may also request replacement cards through our website: www.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. You may also seek covered care from a Retail Health Clinic located anywhere within the United States. You do not need a referral to even though we have not contracted with the treating providers, which means they are non-participating providers. The prior approval waiver applies to non-participating providers at Retail Health Clinics, emergency rooms and urgent care centers only.

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copayment, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare 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 member 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 www.priorityhealth.com. This tool makes it easy for members to search for healthcare 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

This plan recognized that transgender, non-binary, and other gender diverse members require health are delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at 800-446-5674 or priorityhealth.com for assistance.

For Lansing area providers, members have in network access through Sparrow Physicians Health Network. A complete listing of these providers can be found at www.sparrow.org/SPHN.

In addition to the online tool, a member can call our customer service department at 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 www.priorityhealth.com. This tool makes it easy for members to search for healthcare providers and facilities nationwide. In addition to the online tool, a member can call our customer service department at 800 446-5674 and a representative will help him or her find a doctor or facility.

For Lansing area facilities, members have in network access through Sparrow Physicians Health Network. A complete listing of these providers can be found at www.sparrow.org/SPHN.

- **Retail Health Clinics**

Retail Health Clinics are a category of walk-in clinics located in retail stores, supermarkets and pharmacies within the United States. Providers at these locations treat uncomplicated minor illnesses and may provide some preventive care services. We have not contracted with the providers for these services, so even though the care is covered under this plan, and the Retail Health Clinic may be located within a participating Plan pharmacy, the providers are considered non-participating or non-Plan providers. However, you do not need a referral from your PCP, another Plan provider or Priority Health before you seek covered services from a Retail Health Clinic.

Even though these providers are considered non-participating, you do not need a referral from your PCP, another Plan provider or Priority Health before you seek covered services from a Retail Health Clinic. Evaluation and Management services will be covered, and you will only be responsible for any applicable deductible, copayments or coinsurance amounts explained in Section 5 of this Brochure.

- **Balance Billing Protection**

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copayment, co-insurance) contact your Carrier to enforce the terms of its provider contract.

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 primary care physician (PCP) provides your primary healthcare, orders lab tests and x-rays, prescribes medication 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 member 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

You do not need a referral from your PCP or Priority Health to seek covered services from a Cigna Network Provider outside the services area (but within the United States) if you are a Covered Dependent child residing outside the Service Area. Prior Approval requirements are described under Other Services below.

You do not need prior approval or a referral from your PCP or Priority Health to seek covered services from a Retail Health Clinic located within the United States.

All other 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 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 Primary Care Physician 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. If you do not get prior approval for the other services, you will be responsible. 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 use. 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, from a Retail Health Clinic within the United States, 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 some of 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 healthcare, including home infusion services and intermittent skilled services
- Supplemental feedings administered via tube or IV
- Genetic testing
- Clinical trials and any services considered experimental, investigational or unproven
- Comprehensive pain and headache programs
- Growth Hormone Treatment

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

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

- for mental health or substance use 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 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 or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800 446-5674. You may also call OPM's Health Insurance 3 at 202 606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800 446-5674. 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, 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.

Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. Newborns must be added to the plan within 30 days to obtain coverage.

- **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, 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 your claim is in reference to a contraceptive, call 800-446-5674.

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. Precertify your hospital stay or, if applicable, arrange for the healthcare 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. When you see your Primary care physician under the Value Option, you pay a copayment of $10 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.

- The calendar year deductible is $0 Self Only, Self Plus One and Self and Family enrollment under the High Option. Under a Self Only, Self Plus One or Self and Family enrollment there is no deductible, and benefits are payable for you on the first date of coverage under High Option.
- The calendar year deductible is $350 Self Only enrollment and $700 for Self Plus One or Self and Family enrollment (not to exceed the Self Only deductible per person) under the Standard Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expense applied to the calendar year deductible for your enrollment reach $350 under the Standard Option. Under a Self Plus One enrollment or a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for you and other eligible family members when the combined covered expenses applied to the calendar year deductible for your enrollment reach $700 (not to exceed the individual deductible per person) under Standard Option.
- The calendar year deductible is $1,500 Self Only enrollment and $3,000 for Self Plus One or Self and Family enrollment (not to exceed the Self Only deductible per person) under the Value Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expense applied to the calendar year deductible for your enrollment reach $1,300 under the Value Option. Under a Self Plus One enrollment or a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for you and other eligible family members when the combined covered expenses applied to the calendar year deductible for your enrollment reach $3,000 (not to exceed the individual deductible per person) under Value Option.

Note: If you change plans during Open Season, you do not have to start a new deductible under prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does 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

For the High, Standard and Value Options, after your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $7,350 Self Only, or $14,700 for a Self Plus One or Self and Family enrollment in any calendar year you do not have to pay any more for covered services. The maximum annual limitation on cost sharing listed under Self Only, $7,350, applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.

Example: Your plan has a $7,350 Self Only maximum out-of-pocket limit and a $14,700 Self Plus One, or Self and Family out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expense of $7,350 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self Plus One or Self and Family out-of-pocket maximum of $7,350, a second family member, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $14,700 for the calendar year before their qualified medical expenses will begin to be covered in full.

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior 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 prior 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 prior 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 prior 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 prior 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.

Differences between our Plan allowance and the bill

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" under certain circumstances. A surprise bill is an unexpected bill you receive from a nonparticipating healthcare provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care – when you have little or no say in the facility or provider from whom you receive care. They can also happen when you receive non-emergency services at participating facilities, but you receive some care from nonparticipating providers.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

In addition, Priority Health adopts and complies with the surprise billing laws of Michigan and NSA protections that hold you harmless from unexpected bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.priorityhealth.com/fehb or contact the health plan at 1-800-446-5674.

The link to our plan website with surprise billing information in plain language on https://www.priorityhealth.com/landing/surprise-billing:

(1) the restrictions on balance billing in certain circumstances,

(2) any applicable state law protections against balance billing,

(3) the requirements described under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and

(4) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

The Federal Flexible Spending Account Program - FSAFEDS

- **Healthcare FSA (HCFSA)** – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you, your tax dependents, and your 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.

Section 5 High, Standard and Value Option Benefits

Pages 103-105 are benefit summaries for each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5 High, Standard and Value Option Benefits Overview

This plan offers a High, Standard, and Value Option. All 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, Standard, and Value Option Section 5 are divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsection. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain more information about the High, Standard or Value Option, contact us at 800 446-5674 or on our website at www.priorityhealth.com.

Our plans offer unique features that:

- Allow you to see an in-network physician *without* a referral from your Primary Care Physician
- 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, before you seek services
- 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

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
- 10% coinsurance for all inpatient and outpatient labs and x-rays
- $10 copayment for non-preventive Primary care physician visits
- $35 copayment for Specialist office visits
- $15 Generic/ $50 Preferred brand / $80 Non-preferred brand copayment for prescription drugs
- 20% coinsurance for Preferred Specialty drugs ($150 limit for 31-day supply)
- 20% coinsurance for Non-preferred Specialty drugs ($300 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 includes the following differences:

- $350 Self Only and $700 for Self Plus One or Self and Family deductible
- 20% coinsurance for hospital services
- $15 copayment for Primary Care physician visits
- $45 copayment for Specialists office visits
- $20 Generic/ $60 Brand / $90 Non-preferred Brand copayment for prescription drugs
- 20% coinsurance for Preferred Specialty drugs ($200 limit for 31-day supply)
- 20% coinsurance for Non-preferred Specialty drugs ($400 limit for 31-day supply)

Value Option

The Value Option offers the same high level of service that comes with the High and Standard Options. This option has slightly lesser benefits, but will cost you less in premiums. The Value Option includes the following differences:

- $1,500 Self Only and $3,000 for Self Plus One or Self and Family deductible
- 10% coinsurance for hospital services
- $10 copayment for Primary Care physician visits
- $35 copayment for Specialists office visits

- $20 Generic/ $60 Brand / $90 Non-preferred Brand copayment for prescription drugs
- 20% coinsurance for Preferred Specialty drugs ($200 limit for 31-day supply)
- 20% coinsurance for Non-preferred Specialty drugs ($400 limit for 31-day supply)

In addition to joining one of Priority Health's plan options, we also want to encourage any eligible individual to also enroll in original Medicare Part B. Not only will we coordinate coverage under our plan with your Medicare Part B coverage, which alone could reduce your out-of-pocket expenses, we will also waive deductibles and certain copayments under all plan options. See Section 9 for additional information.

Section 5(a) Medical Services and Supplies Provided by Physicians and Other Healthcare 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, except that which is provided at a Retail Health Clinic within the United States.
- 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.
- There is no calendar year deductible under the High Option.
- The calendar year deductible under the Standard Option is: $350 per person (Self Only enrollment) and $700 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- The calendar year deductible under the Value Option is: $1,500 per person (Self Only enrollment) and $3,000 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).
- To build your personalized list of preventive services go to https://health.gov/myhealthfinder

Benefit Description	You pay		
Diagnostic and treatment Services	**High Option**	**Standard Option**	**Value Option**
Professional services of physicians • In physician's office • Telephonic visits • Through secure electronic portal	$10 copayment per Primary care physician visit $35 copayment per Specialist visit	$15 copayment per Primary care physician visit $45 copayment per Specialist visit	$10 copayment per Primary care physician visit $35 copayment per Specialist visit, deductible applies to specialist visit
Professional services of physicians • During an inpatient or outpatient hospital stay • At an ambulatory surgery center • At Home • Advance care planning	No charge	20% coinsurance Deductible applies	10% coinsurance Deductible applies
Retail Health Clinics (A category of walk in clinics located in retail stores, supermarkets and pharmacies within the United States that treat uncomplicated minor illnesses and provide some preventive health care services.)	$35 copayment per visit for evaluation and management services only	$45 copayment per visit for evaluation and management services only Deductible does not apply	$35 copayment per visit for evaluation and management services only Deductible does apply

Diagnostic and treatment Services - continued on next page

Benefit Description	You pay		
Diagnostic and treatment Services (cont.)	**High Option**	**Standard Option**	**Value Option**
Telehealth Visits - Medical Virtual (video) visits and e-visits are available 24/7. To schedule a telehealth visit, please schedule your visit through your member center at www.priorityhealth.com.	No charge	No charge	No charge
Teletherapy Visits - Behavioral Health Virtual (video) visits are available 24/7. To schedule a teletherapy visit, please schedule your visit through your member center at www.priorityhealth.com.	No charge	No charge	No charge
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**	**Value Option**
Test (in a non-hospital facility or physician's office) such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	10% coinsurance for all inpatient and outpatient labs and x-rays Appropriate office visit copayment (Primary care physician or Specialist) may apply for office services	20% coinsurance Deductible applies Appropriate office visit copayment (Primary care physician or Specialist) may apply for office services)	10% coinsurance Deductible applies Appropriate office visit copayment (Primary care physician or Specialist) may apply for office services)
Advanced Diagnostic Imaging Services (Such as CT, MRI, MRA, 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	$150 copayment (copayment waived if performed while confined in a hospital as an inpatient) Deductible applies Maximum 10 copayments per individual per contract year
Not covered Services related to dental care are excluded	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Preventive care, adult	**High Option**	**Standard Option**	**Value Option**
Routine physical every year Individual counseling on prevention and reducing health risks The following preventive services are covered at the time interval recommended at each of the links below. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive benefits for women go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	No charge	No charge	No charge
• Routine mammogram - covered	No charge	No charge	No charge
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	No charge	No charge	No charge
Not covered:	All charges	All charges	All charges

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Value Option**
• *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	All charges	All charges	All charges
Preventive care, children	**High Option**	**Standard Option**	**Value Option**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	No charge	No charge	No charge

Benefit Description	You pay		
Maternity care	**High Option**	**Standard Option**	**Value Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes • Delivery • Postnatal care Notes: • Routine prenatal visits, gestational diabetes screening, and postnatal visits are covered under the "Preventive Care" category above. • Attendance at an approved maternity education program is Covered at no charge. • Visits and consultations for complications of pregnancy are covered as described under the "Diagnostic and treatment services" category above. • 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. • Any facility or physician fees for non-maternity care will be covered at the appropriate benefit level. • When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	No charge	No charge Deductible *does not* apply	No charge Deductible *does not* apply
Breastfeeding support, supplies and counseling for each birth	No charge	No charge Deductible *does not* apply	No charge Deductible *does not* apply
Family planning	**High Option**	**Standard Option**	**Value Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms	$10 copayment for Primary Care Physician office and $35 copayment when performed in Specialist office.	$15 copayment for Primary Care Physician office and $45 copayment when performed in Specialist office. Deductible does *not* apply.	$10 copayment for Primary Care Physician office and $35 copayment when performed in Specialist office. Deductible does *not* apply.

Family planning - continued on next page

Benefit Description	You pay		
Family planning (cont.)	**High Option**	**Standard Option**	**Value Option**
Note: We cover oral contraceptives under the prescription drug benefit.	$10 copayment for Primary Care Physician office and $35 copayment when performed in Specialist 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.	$15 copayment for Primary Care Physician office and $45 copayment when performed in Specialist 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.	$10 copayment for Primary Care Physician office and $35 copayment when performed in Specialist office. Deductible does *not* apply. 10% coinsurance for physician services when performed in an inpatient or outpatient facility in connection with other covered inpatient or outpatient surgery. Deductible applies. 10% coinsurance for outpatient and inpatient facility charges only when in connection with other covered inpatient and outpatient surgery. Deductible applies.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**	**Value Option**
Diagnosis and treatment of infertility: • Treatment of the underlying cause infertility • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) - In vitro fertilization (IVF) • Fertility drugs (see note below) - We cover Injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit • Prior authorization does not apply	50% coinsurance	50% coinsurance Deductible of $350 self only and $700 self plus one and self and family applies to inpatient/outpatient facility and does not apply to services rendered in the physician (specialist) office.	50% coinsurance Deductible of $1500 self only and $3000 self plus one and self and family applies to inpatient/outpatient facility and services rendered in the physician (specialist) office.

Infertility services - continued on next page

Benefit Description	You pay		
Infertility services (cont.)	**High Option**	**Standard Option**	**Value Option**
• If you leave the FEHB plan prior to completion of services, any costs incurred for applicable services currently in progress will become the responsibility of you as the member Iatrogenic Infertility (Fertility Preservation): • This benefit has a $50,000 lifetime maximum and does not require preauthorization. This addition will expand the Carrier's Infertility benefits as follows: • Covered services include: - Sperm count, freezing, thawing, and storage - Egg freezing, thawing and storage (Iatrogenic Preservation egg storage has no time limit) • Members who leave Priority Health prior to the completion of these services will be responsible for any costs incurred for applicable services received after their enrollment has been terminated, including continued storage. The Carrier defines infertility as the inability to achieve a pregnancy after 12 months of unprotected intercourse (after 6 months if the female partner is over age 35).	50% coinsurance	50% coinsurance Deductible of $350 self only and $700 self plus one and self and family applies to inpatient/outpatient facility and does not apply to services rendered in the physician (specialist) office.	50% coinsurance Deductible of $1500 self only and $3000 self plus one and self and family applies to inpatient/outpatient facility and services rendered in the physician (specialist) office.
Not covered: • *Assisted reproductive technology (ART) procedures, such as embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • Charges for assisted reproduction or artificial conception services performed while not a member of this plan. • Services performed prior to meeting the definition of Infertility as described. • Services performed if the individual on whom the procedure is being performed is not an eligible member, including but not limited to donor charges, fees, and services; services associated with donor sperm and donor oocytes, infertility services and fees rendered to a surrogate.	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Allergy care	**High Option**	**Standard Option**	**Value Option**
Testing and treatment Allergy injections Allergy serum	No charge	No charge Deductible does not apply	No charge For testing, office visit copayment may apply Deductible does apply
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**	**Value 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 57. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone treatment is covered under the prescription drug benefit as a preferred and non-preferred specialty benefit. - Requires prior authorization prior to any coverage. • If approved, members would need to fill with our specialty pharmacy Accredo. - Link to the prior authorization forms https://www.priorityhealth.com/drug-authorization-forms-list. Reference forms under "Human Growth Hormone". The names of the growth hormone drugs are listed on the form. - Review drug names to verify coverage on our approved drug list https://www.priorityhealth.com/formulary.	No charge	20% coinsurance Deductible applies	20% coinsurance Deductible applies

Treatment therapies - continued on next page

Benefit Description	You pay		
Treatment therapies (cont.)	**High Option**	**Standard Option**	**Value Option**
- We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* in section 3.	No charge	20% coinsurance Deductible applies	20% coinsurance Deductible applies
Physical and occupational therapies	**High Option**	**Standard Option**	**Value Option**
60 visits per condition, (combined for Physical, Occupational, and Speech Therapies and/or Chiropractic care) 60 visits per condition - cardiac rehabilitation combined with pulmonary rehabilitation Note: We only cover therapy when a physician: • Orders the care • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed.	$10 copayment per visit	$15 copayment per visit Deductible does *not* apply	$10 copayment per visit Deductible applies
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Cognitive Therapy*	*All charges*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**	**Value Option**
60 visits per condition, (combined for Physical, Occupational, and Speech Therapies and/or Chiropractic care) *Treatment of Autism Spectrum Disorder is listed under the Autism Spectrum Disorder services section*	$10 copayment per visit	$15 copayment per visit Deductible does *not* apply	$10 copayment per visit Deductible applies

Benefit Description	You pay		
Autism Spectrum Disorder services	**High Option**	**Standard Option**	**Value Option**
Physical, occupational, and speech therapy	$10 copayment per visit	$15 copayment per visit Deductible does *not* apply	$10 copayment per visit Deductible applies
Applied Behavioral Analysis (ABA) Note: Prior authorization is required Note: Physical, occupational, and speech therapy and Applied Behavioral Analysis (ABA) coverage for treatment of Autism Spectrum Disorder is available for children and adolescents through under age 19. Multiple copayments may apply during one day of service.	$10 copayment per visit	$15 copayment per visit Deductible *does not* apply	$10 copayment per visit Deductible applies
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**	**Value Option**
One hearing screening, performed as part of a physical exam, during each calendar year to determine hearing loss.	No charge	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*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**	**Value Option**
One preventive vision screening, performed as part of a physical exam, during each calendar year to determine vision loss for all ages, including children.	No charge	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 other vision care services	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Foot Care	**High Option**	**Standard Option**	**Value 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 $35 copayment per office visit to a Specialist	$15 copayment per office visit to your Primary care physician $45 copayment per office visit to a Specialist Deductible does *not* apply	$10 copayment per office visit to your Primary care physician $35 copayment per office visit to a Specialist Deductible applies
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*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**	**Value Option**
Artificial limbs and eyes Prosthetic sleeve or sock Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy Corrective orthopedic devices for the non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Prior Approval required for devices over $1,000 Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	50% coinsurance	50% coinsurance Deductible applies	50% coinsurance Deductible applies
All orthotics with the exception of foot orthotics Prior Approval required for devices over $1,000	50% coinsurance	50% coinsurance Deductible applies	50% coinsurance Deductible applies

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay		
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**	**Value Option**
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*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**	**Value Option**
Diabetes Supplies furnished by a participating durable medical equipment provider are covered at 100%. Please see a list below of those supplies covered: • Blood Glucose Monitors • Syringes, lancets and blood glucose test strips • Insulin Pumps • Shoe inserts for members with diabetic neuropathy • Special Shoes prescribed for a person with diabetes when medically/clinically necessary	No charge	No charge	No charge
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 Prior Approval required for devices over $1,000	50% coinsurance	50% coinsurance Deductible applies	50% coinsurance Deductible applies
Medical Foods Supplemental feedings administered via tube. This type of nutrition therapy is also known as enteral feeding. Formulas intended for this type of feeding as well as supplies, equipment, and accessories needed to administer this type of nutrition therapy are covered.	50% coinsurance	50% coinsurance Deductible applies	50% coinsurance Deductible applies

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay		
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**	**Value Option**
Supplemental feedings administered via an IV. This type of nutrition therapy is also known as parenteral nutrition. Nutrients, supplies and equipment needed to administer this type of nutrition are covered. Oral nutritional formula for Inborn Errors of Metabolism (IEM is a covered benefit when all of the following are met: The formula is a medical food labeled and used for the dietary management of an IEM that interferes with the metabolism of specific nutrients (e.g. PKU), Homocystinuria, Maple Syrup Urine Disease), and Nutrition is ordered and managed by a team consisting of a board-certified clinical or medical biochemical geneticist and a metabolic dietician, and The following limits and exclusions apply: Formula that meets the criteria in the above is covered at the DME/Supplies benefit level as defined in coverage documents. Formulas, food products, and supplements that do not require a physician's order are not a covered benefit (e.g. grocery products for a low-protein diet). When criteria 1 and 2 above are met, coverage for IEM formula is not limited by age, weight, or lab values.	50% coinsurance	50% coinsurance Deductible applies	50% coinsurance 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*	*All charges*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay		
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**	**Value Option**
- *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*	*All charges*
Home health services	**High Option**	**Standard Option**	**Value 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	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*	*All charges*
Chiropractic care (spinal manipulations)	**High Option**	**Standard Option**	**Value Option**
60 visits per condition, (combined for Physical, Occupational, and Speech Therapies and/or Chiropractic care)	$10 copayment per visit	$15 copayment per visit Deductible *does not* apply	$10 copayment per visit Deductible applies
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*	*All charges*

Benefit Description	You pay		
Alternative integrative holistic health care	**High Option**	**Standard Option**	**Value Option**
Not covered: *Acupuncture and Non-traditional services, including but not limited to:* • *Massage therapy* • *Yoga* • *holistic/homeopathic treatment*	*All charges*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**	**Value Option**
Care manager assistance Tobacco Cessation programs, including individual/group/telephone counseling, over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Diabetes self management Childhood obesity screening programs and treatment interventions	No charge	No charge	No charge

Section 5(b) Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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.
- There is no calendar year deductible under the High Option.
- The calendar year deductible under the Standard Option is: $350 per person (Self Only enrollment) and $700 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- The calendar year deductible under the Value Option is: $1,500 per person (Self Only enrollment) and $3,000 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- 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.
- **Prior approval is required for inpatient services except in an emergency.**

Benefit Description	You pay		
Surgical procedures	**High Option**	**Standard Option**	**Value 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	20% coinsurance when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies	10% 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	No charge	20% coinsurance Deductible applies	10% coinsurance Deductible applies

Surgical procedures - continued on next page

Benefit Description	You pay		
Surgical procedures (cont.)	**High Option**	**Standard Option**	**Value Option**
• Reconstructive surgery - Blepharoplasty of upper lids - Breast reduction - Panniculectomy - Rhinoplasty - Septorhinoplasty - Surgical treatment of male gynecomastia • Skin disorder treatments - Scar revisions - Keloid scar treatment - Treatment of hyperhidrosis - Excision of lipomas - Excision of seborrheic keratosis - 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. Bariatric surgery is covered when medically/clinically necessary.	No charge	20% coinsurance Deductible applies	10% coinsurance Deductible applies
Not covered: • *Reversal of voluntary sterilization* • *Cosmetic surgery* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**	**Value Option**
Reconstructive surgery to correct congenital birth defects and/or effects of illness or injury 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: • causes 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),	No charge	20% coinsurance when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies	10% 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**	**Value Option**
• interfere 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, and We reasonably expect the surgery to correct the condition, and 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. 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. Gender Affirming surgery Services for gender transformation will be considered if medically/clinically Necessary as determined in accordance with our medical policies. Covered Services for gender affirmation surgery, including pre-and post-hormone therapy are limited to specific treatments outlined in our medical policies and must be provided by a facility approved in advance by us. Gender affirming surgery, including pre- and post-surgical hormone therapy, is considered medically necessary when **ALL** of the following criteria are met: • age 18 or older, ***AND*** • has confirmed gender dysphoria, ***AND*** • capacity to make a fully informed decision and to consent for treatment.	No charge	20% coinsurance when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies	10% 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**	**Value Option**
If medically necessary criteria for coverage for gender affirming surgery are met, the following conditions of coverage apply: • Breast surgery (i.e., initial mastectomy, breast reduction) is considered medically necessary for female to male patients when there is one letter of support from a qualified mental health professional. Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy. • Gonadectomy (Hysterectomy and salpingo-oophorectomy in female-to-male and orchiectomy in male-to-female patients) when **BOTH** of the following additional criteria are met: - Recommendation for gender affirming surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (At least one letter should be a comprehensive report). Two separate letters or one letter with two signatures is acceptable. One letter from a Master's degree mental health professional is acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist, ***AND*** - Documentation of at least 12 months of continuous hormonal gender affirming therapy. • Genital Reconstructive surgery (i.e., including colpectomy vaginectomy, urethroplasty, metoidioplasty with initial phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male patients; including colovaginoplasty penectomy, vaginoplasty, labiaplasty, and clitoroplasty repair of introitus, construction of vagina with graft, coloproctostomy in male to female patients) when **ALL** of the following criteria are met:	No charge	20% coinsurance when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies	10% 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**	**Value Option**
- Recommendation for gender affirming surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (At least one letter should be a comprehensive report). Two separate letters or one letter with two signatures is acceptable. One letter from a Master's degree mental health professional is acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist, ***AND*** - Documentation of at least 12 months of continuous hormonal gender affirming therapy (May be simultaneous with real life experience.), ***AND*** - The individual has lived within the desired gender role for at least 12 continuous months, which includes a wide range of life experiences and events (e.g., family events, holidays, vacations, season-specific work or school experiences), including notification to partners, family, friends, and community members (e.g., at school, work, other settings) of their identified gender., ***AND*** - The individual is an active participant in a recognized gender identity treatment program. • A limited number of electrolysis or laser hair removal sessions may be considered medically necessary for skin graft preparation for genital surgery. • Procedures associated with gender affirming surgery that are performed solely for the purpose of improving or altering appearance or self-esteem related to one's appearance, are considered cosmetic in nature and not medically necessary. • The following are considered cosmetic in nature and not medically necessary when performed as a component of a gender affirming, even when there is a benefit for gender reassignment surgery (this list may not be all-inclusive): - Blepharoplasty, brow reduction, brow lift - Breast enlargement procedures, including augmentation mammoplasty, implants, and silicone injections of the breast	No charge	20% coinsurance when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies	10% 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**	**Value Option**
- Chin augmentation (reshaping or enhancing the size of the chin) - Chin, nose, cheek implants - Face lift, forehead lift - Facial reconstruction for feminization or masculinization - Forehead augmentation - Gluteal and hip augmentation - Hair reconstruction (transplantation or removal, except as noted in I D above) - Jaw/mandibular reduction or augmentation - Liposuction, lipofilling - Lip reduction or enhancement - Mastopexy - Nipple/areola reconstruction - Pectoral implants - Rhinoplasty - Skin resurfacing (e.g. dermabrasion, chemical peel) - Trachea shave (Adam's apple shaving) or reduction thyroid chondroplasty - Voice modification surgery	No charge	20% coinsurance when provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies	10% 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 a mastectomy was performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and • Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema. The requirement to receive services within two years of the event that caused the impairment does not apply to reconstructive surgery following breast cancer. 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	20% coinsurance for services provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center Deductible applies	10% 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**	**Value Option**
Not covered: Cosmetic services, prescription drugs, treatment, therapies or procedures done primarily to improve the way any part of the body looks. Coverage is excluded for, among other things: • Blepharoplasty of lower lids. • Breast augmentation except when provided as part of post-mastectomy reconstructive services. • Chemical peel for acne. • Collagen implants. • Diastasis recti repair. • Excision or repair of excess or sagging skin, however, a panniculectomy is Covered according to our medical policies. • Fat grafts, unless an integral part of another Covered procedure. • Hair transplants or repair of any congenital or acquired hair loss, including hair analysis. • Liposuction, unless an integral part of another Covered procedure. • Orthodontic treatment, even when provided along with reconstructive surgery. • Removal for excessive hair growth by any method, even if caused by an underlying medical condition. • Rhytidectomy (wrinkle removal). • Rhinophyma treatment. • Salabrasion. • Spider vein removal. • Tattoo removal. • Any procedure or treatment for gender reassignment that is not medically/clinically necessary or is considered cosmetic, experimental or investigational. 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.	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Oral and maxillofacial surgery	**High Option**	**Standard Option**	**Value 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. $15 copayment for services provided in a Specialist office	20% coinsurance for services provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center, deductible applies $45 copayment if services provided in a Specialist office	10% coinsurance for services provided during an inpatient hospital stay, outpatient hospital visit or at an ambulatory surgery center, deductible applies $35 copayment if services provided in a Specialist office, 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	50% coinsurance Deductible applies
Orthognathic Surgery	50% coinsurance	50% coinsurance Deductible applies	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**	**Value Option**
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	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*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**	**Value Option**
These solid organ transplants are covered. Solid organ transplants are limited to: These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. See other services under You need prior Plan approval for certain services on page 22. **Solid Organ and Tissues Transplants: Subject to Medical Necessity** • Cornea • Heart • Heart-Lung • Kidney • Kidney-Pancreas • Liver • Pancreas	No charge	20% coinsurance Deductible applies	10% coinsurance Deductible applies

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Value Option**
• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants (small intestine with the liver) or (small intestine with multiple organs, such as the liver, stomach, and pancreas) or isolated small intestine • Lung: single/bilateral/lobar **Blood or Marrow Stem Cell Transplants: Not subject to medical necessity. Plan's denial is limited to indicators for transplant such as refractory or relapsed disease, cytogenetics, subtype, or the diagnosis.** ***Allogeneic transplants for***: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Hodgkin's lymphoma – relapsed • Non-Hodgkin's lymphoma – relapsed • Acute myeloid leukemia • Myeloproliferative Disorders (MPDs)– MD Review • Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) • Hemoglobinopathy MD REVIEW • Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic Syndromes • Paroxysmal Nocturnal Hemoglobinuria MD REVIEW • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome ***Autologous transplants for***: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Hodgkin's lymphoma – relapsed • Non-Hodgkin's lymphoma – relapsed • Amyloidosis • Neuroblastoma	No charge	20% coinsurance Deductible applies	10% coinsurance Deductible applies

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Value Option**
Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity ***Allogeneic transplants for***: • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) ***Autologous transplants for***: • Multiple myeloma • Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors **Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials.** ***Autologous transplants for***: • Childhood rhabdomyosarcoma MD REVIEW • Advanced Ewing sarcoma • Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) • Advanced Childhood kidney cancers **Mini-transplants performed in a Clinical Trial Setting (nonmyeloablative, reduced intensity conditioning for with a diagnosis: Subject to Medical Necessity. There is no defined age limit for the use of reduced intensity conditioning for an allogeneic stem cell transplant.** **Tandem transplants: Subject to medical necessity** ***Autologous tandem transplants for***: • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer) **Transplants Under Clinical Trials** **Blood or Marrow Stem Cell Transplants** ***Allogeneic transplants for***: • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma	No charge	20% coinsurance Deductible applies	10% coinsurance Deductible applies

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Value Option**
• Sickle Cell • Beta Thalassemia Major	No charge	20% coinsurance Deductible applies	10% coinsurance Deductible applies
Non-myeloablative allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Hodgkin's lymphoma • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) relapsed/refractory disease • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple Myeloma • Myeloproliferative Disorders MD Review • Myelodysplasia/Myelodysplastic Syndromes • Sickle Cell disease			
Autologous transplants for: • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma			
Rare Organ/Tissue Transplant ***Allogeneic transplants for***: • Advanced neuroblastoma • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myeloproliferative disorders MD REVIEW • Sickle cell anemia • X-linked lymphoproliferative syndrome			
Autologous transplants for:			

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Value Option**
• Ependymoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma • Waldenstrom's macroglobulinemia MD REVIEW	No charge	20% coinsurance Deductible applies	10% coinsurance Deductible applies
National Transplant Program (NTP) -	*All charges*	*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*	*All charges*
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**	**Value Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	No charge	20% coinsurance Deductible applies	10% 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, except for that which is provided at a Retail Health Clinic within the United States, and you must be hospitalized in a Plan facility.
- There is no calendar year deductible under the High Option.
- The calendar year deductible under the Standard Option is: $350 per person (Self Only enrollment) and $700 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- The calendar year deductible under the Value Option is: $1,500 per person (Self Only enrollment) and $3,000 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **Prior approval is required for inpatient services except in an emergency.**

Benefit Description	You pay		
Inpatient hospital	**High Option**	**Standard Option**	**Value 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	10% coinsurance Deductible applies
Other hospital services and supplies, such as: • Operating, recovery, maternity delivery, and other treatment rooms • Prescribed drugs and medications • 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	No charge 10% Coinsurance for all inpatient and outpatient labs and x-rays.	20% coinsurance Deductible applies	10% coinsurance Deductible applies

Inpatient hospital - continued on next page

Benefit Description	You pay		
Inpatient hospital (cont.)	**High Option**	**Standard Option**	**Value Option**
• Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	No charge 10% Coinsurance for all inpatient and outpatient labs and x-rays.	20% coinsurance Deductible applies	10% coinsurance Deductible applies
Not covered: • *Custodial care* • *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*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**	**Value Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medication • 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 for outpatient hospital visit or at an ambulatory surgery center 10% Coinsurance for all inpatient and outpatient labs and x-rays	20% coinsurance Deductible applies	10% 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	*All charges*

Benefit Description	You pay		
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**	**Value 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	10% 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*	*All charges*
Hospice care	**High Option**	**Standard Option**	**Value 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.	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	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**	**Value Option**
• 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	No charge for care provided in the home Any hospice services provided in a facility will be subject to the appropriate facility benefit
Not covered: • *Custodial care* • *Private duty nursing*	*All charges*	*All charges*	*All charges*
End of Life Care	**High Option**	**Standard Option**	**Value Option**
Advance care planning activity is covered for all members Palliative care for serious chronic illness or terminal illness is part of a member's medical benefit	No charge	20% coinsurance Deductible applies	10% coinsurance Deductible applies
Ambulance	**High Option**	**Standard Option**	**Value Option**
Professional emergency ambulance service when medically appropriate.	$150 copayment	$150 copayment Deductible applies	$150 copayment Deductible applies
Not covered: • *Non-emergency transportation unless you receive prior approval*	*All charges*	*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.
- There is no calendar year deductible under the High Option.
- The calendar year deductible under the Standard Option is: $350 per person (Self Only enrollment) and $700 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- The calendar year deductible under the Value Option is: $1,500 per person (Self Only enrollment) and $3,000 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- 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 is no calendar year deductible under the High Option.

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 to 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**	**Value Option**
Urgent care center services	$75 copayment	$75 copayment Deductible does *not* apply	$75 copayment Deductible applies
Emergency room services	$200 copayment, waived if admitted	$200 copayment, waived if admitted Deductible applies	$200 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*	*All charges*
Emergency/Urgent Care outside our service area	**High Option**	**Standard Option**	**Value Option**
Urgent care center services	$75 copayment	$75 copayment Deductible does *not* apply	$75 copayment Deductible applies
Emergency room services	$200 copayment, waived if admitted	$200 copayment, waived if admitted Deductible applies	$200 copayment, waived if admitted Deductible applies
Not covered: • *Elective care* • *Non-emergency care*	*All charges*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**	**Value Option**
Professional emergency ambulance service when medically appropriate.	$150 copayment	$150 copayment Deductible applies	$150 copayment Deductible applies
Not covered: • *Non-emergency transportation unless you receive prior approval*	*All charges*	*All charges*	*All charges*

Section 5(e) Mental Health and Substance Use Disorder 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 use services. Certain additional services also require Prior Approval from us before they will be Covered. See Section 3 for additional information about Prior Approval requirements.
- There is no calendar year deductible under the High Option.
- The calendar year deductible under the Standard Option is: $350 per person (Self Only enrollment) and $700 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- The calendar year deductible under the Value Option is: $1,500 per person (Self Only enrollment) and $3,000 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- 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 is no calendar year deductible under the High Option.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay		
Mental health services	**High Option**	**Standard Option**	**Value 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 3. Medically/clinically necessary and based on evidence-based standards for treatment of your condition.	$10 copayment for outpatient service	$15 copayment for outpatient services 20% coinsurance for inpatient services Deductible applies	$10 copayment for outpatient services 10% 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**	**Value Option**
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. Teletherapy Visits - Behavioral Health Virtual (video) visits are available 24/7. To schedule a teletherapy visit, please schedule your visit through your member center at www.priorityhealth.com.	$10 copayment for outpatient service No charge	$15 copayment for outpatient services 20% coinsurance for inpatient services Deductible applies No charge	$10 copayment for outpatient services 10% coinsurance for inpatient services Deductible applies No charge
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. • 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	$15 copayment for outpatient services 20% coinsurance inpatient services Deductible applies	$10 copayment for outpatient services 10% 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**	**Value 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	$15 copayment for outpatient services 20% coinsurance inpatient services Deductible applies	$10 copayment for outpatient services 10% coinsurance for inpatient services Deductible applies
Substance use services	**High Option**	**Standard Option**	**Value Option**
When medically/clinically necessary, covered substance use 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, no preauthorization required • Outpatient Treatment • Outpatient/Ambulatory Detoxification	$10 copayment for outpatient services	$15 copayment for outpatient services 20% coinsurance inpatient services Deductible applies	$10 copayment for outpatient services 10% coinsurance inpatient services Deductible applies
Not covered	**High Option**	**Standard Option**	**Value 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*	*All charges*	*All charges*	*All charges*

Not covered - continued on next page

Benefit Description	You pay		
Not covered (cont.)	**High Option**	**Standard Option**	**Value Option**
• *Experimental/investigational or unproven treatments and services* • *Scholastic/educational testing* *Substance use 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*	*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.
- 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.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- 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.
- Priority Health cannot accept return of unopened medications and the member cannot receive a refund. There is a Federal law that prevents a pharmacy from accepting returned medications.

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 certified providers with prescriptive authority prescribing within their scope of practice 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. 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.

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

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

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

- **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 through Accredo Specialty Pharmacy and Meijer Specialty Pharmacy. Priority Health will manage the treatment setting for infusible drug services and may direct you to an infusion center for home setting.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a Brand. If you receive a name brand drug when an FDA approved generic drug is available, you have to pay the difference in cost between the name brand drug and the generic.
- **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.
- **Brand Name Drugs.** If you elect to receive a Brand Name Drug when an equivalent Generic Drug is reasonably available, you may be responsible for the difference in cost between the Brand Name Drug and the Generic Drug. Any monies you paid for the difference in costs between a Generic Drug and the Brand Name Drug (because you elected to receive a Brand Name Drug when the prescription allows a Generic Drug substitution) are non-Covered Services.

Benefit Description	You pay		
Covered medications and supplies	**High Option**	**Standard Option**	**Value 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 blood glucose monitors, syringes, lancets, blood glucose test strips, insulin pumps, shoe inserts for members with diabetic neuropathy, and special shoes prescribed for a person with diabetes when medically/clinically necessary can be purchased at a Plan pharmacy and your applicable prescription drug copayment will apply. These supplies are covered in full if obtained from a participating Durable Medical Equipment (DME) provider.	**Retail Prescriptions:** $15 copayment per Generic prescription $50 copayment for Preferred-brand prescription $80 copayment for Non-preferred Brand prescription 20% coinsurance for Preferred Specialty drugs - The maximum copayment for Preferred Specialty drugs is $150 per fill. Prior approval required 20% coinsurance for Non-preferred Specialty drugs - The maximum copayment for Non-preferred Specialty drugs is $300 per fill. Prior approval required There is no deductible on this plan. You just pay the copayments listed.	**Retail Prescriptions:** $20 copayment per Generic prescription $60 copayment for Preferred-brand prescription $90 copayment for Non-preferred brand prescription 20% coinsurance for Preferred Specialty drugs - The maximum copayment for Preferred Specialty drugs is $200 per fill. Prior approval required 20% coinsurance for Non-preferred Specialty drugs - The maximum copayment for Non-preferred Specialty drugs is $400 per fill. Prior approval required Deductible does not apply to outpatient prescription drugs	**Retail Prescriptions:** $20 copayment per Generic prescription $60 copayment for Preferred-brand prescription $90 copayment for Non-preferred brand prescription 20% coinsurance for Preferred Specialty drugs - The maximum copayment for Preferred Specialty drugs is $200 per fill. Prior approval required 20% coinsurance for Non-preferred Specialty drugs - The maximum copayment for Non-preferred Specialty drugs is $400 per fill. Prior approval required Deductible does not apply to outpatient prescription drugs

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Value Option**
• Drugs used for the treatment of gender dysphoria or gender transformation, such as FDA-approved medications for hormone therapy according to standard requirements for the particular drug (prior approval or step therapy may apply). Hormone therapy for the treatment of gender dysphoria or gender transformation is covered as prescribed by your provider, regardless of gender. • Naloxone 2mg and 2ml strength is covered at no charge. • Growth Hormone Treatment - requires prior approval; If there is no generic equivalent available, you will still have to pay the applicable brand name copayment.	**Retail Prescriptions:** $15 copayment per Generic prescription $50 copayment for Preferred-brand prescription $80 copayment for Non-preferred Brand prescription 20% coinsurance for Preferred Specialty drugs - The maximum copayment for Preferred Specialty drugs is $150 per fill. Prior approval required 20% coinsurance for Non-preferred Specialty drugs - The maximum copayment for Non-preferred Specialty drugs is $300 per fill. Prior approval required There is no deductible on this plan. You just pay the copayments listed. **Mail Order:** Two applicable copayments for a 90-day supply of Generic, Preferred-brand or Non-preferred brand prescription drugs	**Retail Prescriptions:** $20 copayment per Generic prescription $60 copayment for Preferred-brand prescription $90 copayment for Non-preferred brand prescription 20% coinsurance for Preferred Specialty drugs - The maximum copayment for Preferred Specialty drugs is $200 per fill. Prior approval required 20% coinsurance for Non-preferred Specialty drugs - The maximum copayment for Non-preferred Specialty drugs is $400 per fill. Prior approval required 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:** $20 copayment per Generic prescription $60 copayment for Preferred-brand prescription $90 copayment for Non-preferred brand prescription 20% coinsurance for Preferred Specialty drugs - The maximum copayment for Preferred Specialty drugs is $200 per fill. Prior approval required 20% coinsurance for Non-preferred Specialty drugs - The maximum copayment for Non-preferred Specialty drugs is $400 per fill. Prior approval required 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

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Value Option**
Contraceptive drugs and devices as listed in the ACA/HRSA site. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Generic contraceptives (including generic emergency contraceptives) are Covered under preventive health care services at no cost share to you as outlined in Priority Health's Preventive Health Care Guidelines. A brand name contraceptive may be Covered under preventive health care services at no cost share to you when there is no generic equivalent for the same contraceptive method, or if approved by Priority Health as medically/clinically Necessary. All other brand name contraceptive drugs are subject to the applicable Brand Name Drugs copayment described below. Restrictions may apply to Members of (a) religious employer plans certified as exempt under the Patient Protection and Affordable Care Act; and (b) plans certifying Eligible Organization Accommodations under provisions of the Patient Protection and Affordable Care Act.	No charge	No charge	No charge

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Value Option**
Preventive care medications Medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 6 months -1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Prenatal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0 - 6 months • Oral chemotherapy • FDA approved tobacco-cessation products are covered for up to 3 months. Coverage is continued for an additional 3 months if you have successfully quit smoking (a maximum of 6 months per calendar year) Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.	No charge	No charge	No charge
Covered medical pharmacy services drugs include those administered in an inpatient or emergency setting or those requiring an injection or infusion by a health professional in a medical office, home or outpatient facility. Note: Coverage for selected injectable drugs in certain categories is covered under the outpatient prescription drug benefit above.	20% coinsurance for a Preferred Specialty Drug. The maximum copayment for a Preferred Specialty Drug is $150 20% coinsurance for a Non-preferred Specialty Drug. The maximum copayment for a Non-preferred Specialty Drug is $300 Prior approval required	20% Coverage for a Preferred Specialty Drug. The maximum copayment for a Preferred Specialty Drug is $200 20% Coverage for a Non-preferred Specialty Drug. The maximum copayment for a Non-preferred Specialty Drug is $400 Prior approval required	20% Coverage for a Preferred Specialty Drug. The maximum copayment for a Preferred Specialty Drug is $200 20% Coverage for a Non-preferred Specialty Drug. The maximum copayment for a Non-preferred Specialty Drug is $400 Prior approval required

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Value Option**
		Deductible will apply to covered inpatient medical plan pharmacy services.	Deductible will apply to covered inpatient medical plan pharmacy services.
Drugs used to treat sexual dysfunction	50% coinsurance for up to 6 pills per 30 days (oral and non-oral)	50% coinsurance for up to 6 pills per 30 days (oral and non-oral)	50% coinsurance for up to 6 pills per 30 days (oral and non-oral)
Drugs used for the purpose of treating infertility	50% coinsurance	50% coinsurance	50% coinsurance
Naloxone therapy (2mg and 2ml strength)	No charge	No charge	No charge
Anti-Obesity Medications (generic only)	$15 copayment	$20 copayment	$20 copayment
Gene Therapy (Prescription Drugs) All Priority Health plans include coverage of services, drugs and supplies related to the treatment of gender dysphoria. Covered services, when medically necessary, are available for all members subject to medical policy. Preventive services are covered subject to the plan benefits, including Affordable Care Act requirements, as recommended by a member's physician regardless of the member's gender assigned at birth. Gender edits are not in place on our prescription drug formulary to ensure members are able to access covered drugs when prescribed by an authorized provider.	No charge. If an office visit is billed, the office visit copayment will be $10 for a PCP and $35 for a Specialist. There is no member cost share for an outpatient or inpatient facility.	No charge. If an office visit is billed, the office visit copayment will be $15 for a PCP and $45 for a Specialist. The member cost share for an outpatient or inpatient facility will be 20%, subject to the deductible.	No charge. If an office visit is billed, the office visit copayment will be $10 for a PCP and $35 for a Specialist. The member cost share for an outpatient or inpatient facility will be 10%, subject to the deductible.
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). • Men's contraceptives.	*All charges*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Value Option**
• 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*	*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.
- 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.
- There is no calendar year deductible under the High Option.
- The calendar year deductible under the Standard Option is: $350 per person (Self Only enrollment) and $700 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- The calendar year deductible under the Value Option is: $1,500 per person (Self Only enrollment) and $3,000 per family (Self Plus One and Self and Family enrollment). The calendar year deductible applies to most benefits in this Section.
- 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		
Accidental injury benefit	**High Option**	**Standard Option**	**Value 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.	$35 copayment in a Specialist office	$45 copayment in a Specialist office Deductible does *not* apply	$35 copayment in a Specialist office Deductible applies
Dental Benefits	**High Option**	**Standard Option**	**Value Option**
We have no other dental benefits	*All Charges*	*All Charges*	*All Charges*

Section 5(h) Wellness and Other Special Features

No Referrals	You don't need a referral from your Primary care physician to see an in-network Specialist.
Worldwide Emergency and Urgent Care	No matter where you travel, we provide worldwide emergency and urgent care
Virtual Visit Services	See a doctor 24/7 from home at no charge to you 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 by logging into their member center at *priorityhealth.com*. Remember! Your Primary care physician is always the first person you should call when you're sick. He/she knows you and your health, so he/she is the best place to go for routine care, preventive checkups and chronic condition management. He/she may also have options for you to get care quickly, even when their office is closed. Get care anytime, anywhere with e-visits e-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 does e-visit care treat? eCare visits treats non-emergency conditions, such as: Cold and flu Fever Respiratory infections Sinus infections Sore throats See more about e-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
Retail Health Clinic	Retail Health Clinics are a category of walk-in clinics that are located in retail stores, supermarkets and pharmacies. The centers teat uncomplicated, minor illnesses and provide some preventive health care services. Evaluation and management services are covered at Retail Health Clinics with the applicable Specialist copayment for contracted facilities.
Cost Estimator	With the Cost Estimator tool, you can see your estimated out-of-pocket costs based on your health plan and deductible, and you can choose a lower-cost option to save money on high-quality care.
Active and Fit	The Active&Fit Direct program allows you to choose from 9,000+ participating fitness centers nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes). The program offers: • Online directory maps and locator for fitness centers (available on any device) • A free guest pass to try out a fitness center before enrolling (where available) • The option to switch fitness centers to make sure you find the right fit • Online fitness tracking from a wide variety of popular wearable fitness devices, apps, and exercise equipment • Visit https://www.activeandfitdirect.com/ to search a location near you
Care Management	As an FEHB member, you have a Dedicated Care Manager who can help you in the following ways: • Learn and manage your conditions like asthma, hypertension and diabetes • Connect with resources to help you be your healthiest • Find an in network doctor or Specialist • navigate the health care system and coordinate your care Call the number on the back of your card to be transferred to your Dedicated Care Manager.
Priority Health Member Account	Your Priority Health member account gives you access to your health information in one convenient place. From renewing prescriptions to scheduling a telehealth visit and even checking the price of health care services before you get care, your Priority Health account puts you in control of your health. Set up your Priority Health account today. • Download the Priority Health app from the App Store or Google Play, or visit *member.priorityhealth.com*. • Click Sign up and follow the instructions

	To ensure the highest level of security for our members, Priority Health uses and authentication and fraud prevention service that validates a member's identify in real time, reducing the risk of identity impersonation. Priority Health does not use or store this information.
Medication therapy management	Medication therapy management (MTM) is prescription management for members with chronic conditions. For members dealing with multiple chronic conditions, an annual medication review is just as important as a yearly physical. Qualified members receive a free 30 minute face to face visit with a pharmacist to review their medications and simplify their regimen, keeping them healthy, productive and on the job. During the MTM consultation, the pharmacist will: • Review all medications and if applicable, help simplify the member's medication regimen • Recommend alternative drugs to relive any side effects • Resolve concerns that a member has about their medications, including working with their doctor to make changes to help them feel better • Provide education on how to take drugs, so members get the best results • Offer suggestions, such as generic alternatives, that can save money • Support medication adherence for those not taking their medicine and help remove barriers • Create a master list of all medications that a member can share with their doctor during appointments Call the number on the back of your card for further information.

Non-FEHB Benefits Available to Plan Members

PriorityMOM program

PriorityMOM, which stands for Maternity Offering for Members, is a Priority Health program designed to help moms and families navigate health care costs and coverage throughout pregnancy and beyond. The goal? To promote healthier pregnancies and reduce the total cost of maternity care, the number of and cost of preterm births, and post-partum readmissions. Please visit https://www.priorityhealth.com/prioritymom-maternity-program for more details.

How it works:

Priority Health will target expectant mothers and deliver a personalized, multi-touch, multimedia experience to acquire program participants.

Members who opt-in to the program will receive a welcome gift that contains Blood pressure cuff, baby sleep sack, and program overview. The forehead thermometer is the gift for second time PriorityMOM participant.

Throughout their pregnancy, participants will receive information around their costs and coverage as well as educational resources. Those with high-risk conditions will receive additional outreach to help manage those conditions.

At the end of the program, participants will receive a $50 cash gift card when they complete the program survey.

Wellness benefit

Subscribers and Spouses earn a $60 cash gift card which is not restricted to medical services. You can obtain this reward between January 1st and December 31st by logging in to your Priority Health account and completing your health risk assessment. Instructions on how to complete your health risk assessment are listed below:

Step 1 – Login to your Priority Health account

Step 2 – Click on Health Living

Step 3 – Click on Wellbeing Hub and select Go There

Step 4 – The Health Assessment will be the first action a member will see when they log into the Wellbeing Hub for the first time.

A member will earn points for completing the Health Assessment which they can then redeem for a Gift Card right on the wellbeing hub.

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, Retail Health Clinics, 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 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 providers, 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 or Retail Health Clinic 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. Providers 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 provider 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 healthcare 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 healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8 The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about 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/fehb,* please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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 1145, P.O. Box 269, Grand Rapids, MI 49501-0269, or by calling 800 446-5674.

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

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 healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

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

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 1145, P.O. Box 269, Grand Rapids, MI 49501-0269, or send us a secure email from Priority Health Mailbox in your MyHealth Message Center on our website at 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.

3

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

You must write to OPM within:

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

Write OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 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 healthcare 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, FEHB 3 division at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9 Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare 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, contact Priority Health Customer Service at 800-446-5674.

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 processes the benefit, 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 healthcare 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 or employing 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

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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 proceding 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

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

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

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

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

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

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

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

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

Clinical Trials

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

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan 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

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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 waive some costs if you have Medicare Part A and B and your Original Medicare Plan is your primary payor.

- Medical services and supplies provided by physicians and other healthcare professionals

Please review the following examples which illustrates your cost share if you are enrolled Medicare Part A and B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible - you pay $0 with Medicare Part B for all plans (high, standard, value)
High Option You pay without Medicare Part A and B: $0.00
Standard Option You pay without Medicare Part A and B:$350 Self Only $700 Self Plus One and Self and Family
Value Option you pay without Medicare Part A and B: $1,500 Self Only $3,000 Self Plus One and Self and Family

Benefit Description: Primary Care Physician - you pay $0 with Medicare Part B for all plans (high, standard, value)
High Option You pay without Medicare Part B: $10.00
Standard Option You pay without Medicare Part B: $15.00
Value Option you pay without Medicare Part B: $10.00

Benefit Description: Specialist - you pay $0 with Medicare Part B for all plans (high, standard, value)
High Option You pay without Medicare Part B: $35.00
Standard Option You pay without Medicare Part B: $45.00
Value Option you pay without Medicare Part B: $35.00

Benefit Description: Inpatient Hospital - you pay $0 with Medicare Part B for all plans (high, standard, value)
High Option You pay without Medicare Part B: $0.00
Standard Option You pay without Medicare Part B:20%
Value Option you pay without Medicare Part B: $10%

Benefit Description: Outpatient Hospital - you pay $0 with Medicare Part B for all plans (high, standard, value)
High Option You pay without Medicare Part B: $0.00
Standard Option You pay without Medicare Part B:20%
Value Option you pay without Medicare Part B: $10%

Benefit Description: Emergency Care - you pay $0 with Medicare Part B for all plans (high, standard, value)
High Option You pay without Medicare Part B: $200.00
Standard Option You pay without Medicare Part B: $200.00
V**alue Option** you pay without Medicare Part B: $200.00

Benefit Description: Ambulance Services - you pay $0 with Medicare Part B for all plans (high, standard, value)
High Option You pay without Medicare Part B: $150.00
Standard Option You pay without Medicare Part B: $150.00
Value Option you pay without Medicare Part B: $150.00

Benefit Description: Urgent Care - you pay $0 with Medicare Part B for all plans (high, standard, value)
High Option You pay without Medicare Part B: $75.00
Standard Option You pay without Medicare Part B: $75.00
Value Option you pay without Medicare Part B: $75.00

Benefit Description: Durable Medical Equipment / Prosthetics you pay $0 with Medicare Part B for all plans (high, standard, value)
High Option You pay without Medicare Part B: 50%
Standard Option You pay without Medicare Part B: 50%
Value Option you pay without Medicare Part B: 50%

You can find more information about how our plan coordinates benefits with Medicare at www.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 healthcare 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: Priority Health does not offer a Medicare Advantage Plan through the FEHB plan. You may enroll in one of the Individual Medicare Advantage plans offered by Priority Health (non-FEHB) 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 an Individual 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 or employing 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		✓*
9) Are a Federal employee receiving 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. Prior authorization is required.

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

See Section 4, page 25.

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

See Section 4, page 25.

Cost-sharing

See Section 4, page 25.

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	See Section 4, page 26.
Disputed claims process	The process you may follow if you do 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 or retiree eligible to enroll in this plan.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
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 long-term 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 use services is determined by our Behavioral Health Department. In order to be considered medically/clinically Necessary, the services or supplies must: (a) be widely accepted as effective; (b) be appropriate for the condition or diagnosis; (c) be essential, based upon nationally accepted evidence-based standards; and (d) cost no more than a treatment that is likely to yield a comparable health outcome. The determination of whether proposed care is a Covered Service is independent of, and should not be confused with, the determination of whether proposed care is Medically/ Clinically Necessary.
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 except as otherwise stated in this brochure.

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 this protection.
Physician	A licensed medical doctor (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) or surgeon.
Plan Allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
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. Most Plan or participating providers offer services within Priority Health's service area. However, if you are a covered dependent child residing outside the service area, covered services received outside the service area but within the United States are also available from Cigna, a Priority Health leased network provider.
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 Physician ("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.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Residential 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."
Retail Health Clinic	A category of walk in clinic located in retail stores, supermarkets and pharmacies within the United States that treat uncomplicated minor illnesses and provide some preventive health care services.
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.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Substance Use	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.

Subscriber

An FEHB Employee or FEHB Annuitant.

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 determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 800 446-5674. 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.

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Summary of Benefits for the High Option of Priority Health - 2023

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.priorityhealth.com/fehb.
- 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.
- There is no deductible for the High Option.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$10 copayment Primary care physician; $35 copayment Specialist	33-47
Services provided by a hospital: Inpatient	10% coinsurance for all inpatient and outpatient labs and x-rays	61-64
Services provided by a hospital: Outpatient	10% coinsurance for all inpatient and outpatient labs and x-rays	61-64
Urgent Care: In-area	$75 copayment	65-66
Urgent Care: Out-of-area	$75 copayment	65-66
Emergency benefits: In-area	$200 copayment per visit, waived if admitted	65-66
Emergency benefits: Out-of-area	$200 copayment per visit, waived if admitted	65-66
Mental health and substance use disorder treatment:	Regular cost-sharing	67-70
Prescription drugs:	Retail / 30-day supply: $15 copayment per Generic prescription, $50 copayment per Brand prescription, $80 copayment per Non-preferred Brand Preferred Specialty: 20% coinsurance up to a maximum of $150 per fill / Non-preferred Specialty: 20% coinsurance up to a maximum of $300 per fill. Mail Order / 90 day-supply: 2x copayment	71-77
Dental care:	No coverage unless in accidental injury for repair of sound natural teeth.	78
Vision care:	No coverage for routine eye exam	42
Protection against catastrophic costs (your out-of-pocket maximum)**:**	$7,350 Self Only / $14,700 Self Plus One and Self and Family	14

Summary of Benefits for the Standard Option of Priority Health - 2023

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.priorityhealth.com/fehb.
- 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.
- Calendar Year Deductible: $350 Self Only and $700 Self Plus One and Self and Family. Asterisk (*) means subject to deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$15 copayment Primary care physician; $45 copayment Specialist	33-47
Services provided by a hospital: • Inpatient*	20% coinsurance	61-64
• Outpatient*	20% coinsurance	61-64
Urgent Care: • In-area	$75 copayment	65-66
• Out-of-area	$75 copayment	65-66
Emergency benefits: • In-area*	$200 per visit, waived if admitted	65-66
• Out-of-area*	$200 per visit, waived if admitted	65-66
Mental health and substance use disorder treatment:	Regular cost-sharing	67-70
Prescription drugs:	Retail / 30-day supply: $20 copayment per Generic prescription, $60 copayment per Brand prescription, $90 copayment for Non-preferred prescription Preferred Specialty: 20% coinsurance up to a maximum of $200 per fill / Non-preferred Specialty: 20% coinsurance up to a maximum of $400 per fill. Mail Order / 90-day supply: 2x copayment	71-77
Dental care:	No coverage unless in accidental injury for repair of sound natural teeth.	78
Vision care:	No coverage for routine eye exam	42
Protection against catastrophic costs (your out-of-pocket maximum)**:**	$7,350 Self Only / $14,700 Self Plus One and Self and Family	14

Summary of Benefits for the Value Option of Priority Health - 2023

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.priorityhealth.com/fehb.
- 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.
- Calendar Year Deductible: $1500 Self Only and $3000 Self Plus One and Self and Family. Asterisk (*) means subject to deductible.

Value Option Benefits	You Pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copayment: $10 copayment Primary care physician; $35 copayment Specialist*	33-47
Services provided by a hospital: • Inpatient*	10% coinsurance	61-64
• Outpatient*	10% coinsurance	61-64
Urgent Care: • In-area*	$75 copayment	65-66
• Out-of-area*	$75 copayment	65-66
Emergency benefits: • In-area*	$200 copayment per visit, waived if admitted	65-66
• Out-of-area*	$200 copayment per visit, waived if admitted	65-66
Mental health and substance use disorder treatment:	Regular cost-sharing	67-70
Prescription Drugs:	Retail / 30-day supply: $20 copayment per Generic prescription, $60 copayment per Brand prescription, $90 copayment for Non-preferred Prescription Preferred Specialty: 20% coinsurance up to a maximum of $200 per fill / Non-preferred Specialty: 20% coinsurance up to a maximum of $400 per fill. Mail Order / 90-day supply: 2x copayment	71-77
Dental care:	No coverage unless in accidental injury for repair of sound natural teeth.	78
Vision care:	No coverage for routine eye exam	42
Protection against catastrophic costs (your out-of-pocket maximum):	$7,350 Self Only / $14,700 Self Plus One and Self and Family	14

2023 Rate Information for Priority Health

To compare your FEHB health plan options please go towww.opm.gov/fehbcompare**.**

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Michigan					
High Option Self Only	LE1	$259.72	$252.99	$562.73	$548.14
High Option Self Plus One	LE3	$560.52	$567.43	$1,214.46	$1,229.43
High Option Self and Family	LE2	$611.42	$593.44	$1,324.74	$1,285.79
Standard Option Self Only	LE4	$232.28	$77.43	$503.28	$167.76
Standard Option Self Plus One	LE6	$511.03	$170.34	$1,107.23	$369.07
Standard Option Self and Family	LE5	$545.87	$181.95	$1,182.71	$394.23
Michigan					
Value Option Self Only	Y41	$163.82	$54.60	$354.93	$118.31
Value Option Self Plus One	Y43	$360.39	$120.13	$780.85	$260.28
Value Option Self and Family	Y42	$384.97	$128.32	$834.10	$278.03