

Welcome to HealthPlus Insurance Company-General Information

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**Changes in Status
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Welcome. We are pleased to have you as a member of our Preferred Provider Organization (PPO) plan. HealthPlus provides you and your family with comprehensive health benefits and a team of friendly professionals to assist with your customer service needs.

Your PPO Benefit Guide

This benefit guide is provided to you to help you understand your HealthPlus PPO health care plan. It is divided into three main sections. This first section is your HealthPlus PPO Member Handbook. This handbook section explains how your health plan works and what you need to know to get the most from your health care coverage. It tells you how to contact HealthPlus and when you might need to, how to find a preferred-provider at home and when you travel, what preventive services are covered, which services require a Prior Authorization and much more.

Sections two and three of this benefit guide include your Schedule of Benefits document, any optional Benefit Riders and your PPO Certificate of Coverage. These documents include **your Copay and coinsurance** responsibility for covered services. **Please read these sections carefully before you require services so you have a complete understanding of your benefits and your financial responsibility.**

Your are responsible for all Prior Authorization requirements; please see page 16 for details.

Customer Service

You can access HealthPlus PPO customer service via telephone, the Internet and postal mail or in person.

Telephone

The HealthPlus PPO Customer Service Department is available to answer your calls Monday through Friday 9 a.m. to 6 p.m. (ET) at 1-888-212-1512

The telephone number for the deaf is
1-800-992-5070 (TDD).

Internet

You can access our secure Member Services Center from our Web site, www.healthplus.org, 24 hours a day, 7 days a week, 365 days a year ...whenever it is convenient for you.

At the Web site you can do any of the following:

- Change an address
- Order a replacement identification card
- Review coverage and eligibility information
- Review the status of a medical claim and your claim history

Postal Mail or In Person

If you would like to write or visit one of our business offices, the addresses are:

HealthPlus Insurance Company
2050 S. Linden Road
Flint, MI 48532

HealthPlus Insurance Company
5454 Hampton Place
Saginaw, MI 48604

Your HealthPlus PPO Identification Card

Every eligible HealthPlus PPO member in your family is given his or her own HealthPlus PPO identification (ID) card. Your ID card has your name, member identification number, group number, effective date, Copays and prescription drug coverage information if applicable.

Always show your HealthPlus PPO ID card when you visit a physician, medical center or have a prescription filled. You also should have your identification card handy when you call or visit HealthPlus. This helps us serve you quickly and efficiently.

Abbreviations under the **Copay** section on your HealthPlus PPO ID card:

- OV** = Office Visit
- PCP** = Primary Care Physician such as Internist, Pediatrician, or Family Practice Physician
- Spec** = Specialist Physician such as Oncologist, Urologist, Cardiologist, etc.
- ER/UC** = Emergency Room/Urgent Care
- RX** = Prescription (only if rider was purchased. If no pharmacy rider, RX will = NO)

Abbreviations under the **Deductible** section of the ID card are:

- Ind** = Individual deductible (In-Network)
- Fam** = Family deductible (In-Network)

Copay and Deductible information on the ID card are for In-Network Services. Out-of Network Copay and Deductible information can be found on your Schedule of Benefits in Section II of this Benefit Guide.

The back of your ID card has the telephone numbers to call to obtain necessary Prior Authorizations, lists other preferred provider networks in addition to the HealthPlus PPO network, and the address to which your provider should submit claims.

Lost, Stolen or Damaged Cards

Should your HealthPlus PPO ID card become damaged or is stolen or lost, you can order a new card online at www.healthplus.org. You also may contact our Customer Service Department at 1-888-212-1512. It will take approximately 5 to 10 business days for your new ID card(s) to arrive.

Do not allow anyone else to use your ID card. Improper use of your card can result in the cancellation of your health care coverage with HealthPlus.

The diagram shows a HealthPlus PPO ID card with the following information:

- HealthPlus PPO** logo and "HealthPlus Insurance Company"
- ID #**: H999999999
- GROUP**: 54321C, **ISSUER**: (80840) 9876543210
- NAME**: JOHN DOE
- Family Members**: 01 JOHN, 02 JANE, 03 JONATHAN, 04 JESSICA, 05 JOSHUA, 06 JUSTIN
- informed** logo, **RXBIN #610011**, **RXPCN #23050**
- COPAYS**:
 - OV/PCP/Spec: DED & COI (Callout: PCP/Specialist Office Visit Copays)
 - ERAUC: DED & COI/\$0 (Callout: Emergency Room/Urgent Care Facility Copays)
- DEDUCTIBLE**:
 - Ind/Fam: \$150/\$300 (Callout: Individual/Family Deductible)
- COINSURANCE**:
 - In/Out: 20%/40 (Callout: In-Network Coinsurance/Out-of-Network Coinsurance)

The back of the card contains:

- Customer Service Information**: www.healthplus.org, 888-212-1512, TDD: 800-992-5070
- Prior Authorization Information**: Hospital admissions, selected outpatient procedures, and selected prescription medications must be authorized by HealthPlus in advance.
- Claims Information**: Submit claims to: HealthPlus Ins. Co., P.O. Box 1700, Flint, MI 48501-1700
- Additional Networks**: Contact GlobalCare: 866-807-6193 or 770-667-0247. Networks include Cofinity (MI), First Health (Outside MI, IN, IL, OH), Encore (IN), and The Second Health Interest (IL, OH).

Changes in Your Personal Status: When to Contact Your Employer

Some employer groups have unique eligibility requirements concerning who may enroll in the group's plan. Please call your Human Resource Department with any questions concerning eligibility or changes in your personal status for you or your dependent(s) covered under your HealthPlus PPO coverage. Your employer will then notify HealthPlus of the changes so that the appropriate updates can be made to your coverage.

Examples of changes in status that should be reported to your employer:

- Adoption or legal guardianship
- Birth of a child
- Change in dependency status of child or children
- Change in employment status
- Change of address and/or telephone number
- Death
- Divorce
- Legal name change (e.g. due to marriage or divorce)
- Marriage
- Other health care coverage (e.g. Medicare, other commercial coverage)

To ensure your coverage will continue without interruption, report any change in personal status to your employer in writing within 31 days of the change. **Your employer must send these changes to HealthPlus.**

Any new dependents must be enrolled with HealthPlus within 31 days of the dependent becoming eligible. **Enrollment is done through your employer's Human Resource Department by completing an enrollment application form.**

Failure to follow this procedure may result in non-payment of services. If you wait longer than 31 days, you may have to wait until your next group open enrollment period to enroll the new dependent.

Changes in Your Personal Status: When to Contact HealthPlus

You can verify many changes to your personal status by going to our secure Member Services Center from our Web site, www.healthplus.org, or you can contact HealthPlus at:

HealthPlus Customer Service Department
Monday through Friday
9 a.m. – 6 p.m. ET
1-888-212-1512
Telecommunication Device for the Deaf
(TDD) 1-800-992-5070.

Examples of changes in status that can be verified on the secure Member Services Center include:

- Adoption or legal guardianship
- Birth of a child
- Change in dependency status of child or children
- Change in employment status
- Change of address and/or telephone number
- Death
- Divorce
- Legal name change (e.g. due to marriage or divorce)
- Marriage
- Other health care coverage (e.g. Medicare, other commercial coverage)

Other Health Insurance Coverage: Coordination of Benefits

HealthPlus can work with other plans to coordinate benefits and maximize your dual coverage. If you or your dependents have other health care coverage, please contact our Customer Service Department with the name of the other plan.

HealthPlus also coordinates benefits with auto insurance carriers, Medicare, workers' compensation carriers and other payors. You may be required to complete a Coordination of Benefits (COB) questionnaire if:

- a claim is received and other insurance is involved;
- we did not receive your other insurance carrier information on your enrollment application;
- you did not notify HealthPlus of additional health insurance coverage.

HealthPlus reserves the right to recover any and all costs of services to treat conditions covered by any other insurer.

Option to Continue Group Coverage

You, your spouse and any covered children may have the right to continue your group coverage, even after it would otherwise end. This option is provided under federal law, specifically the Consolidated Omnibus Budget Reconciliation Act (COBRA).

For full details, please consult your personnel office or Human Resource Department.

Converting to an Individual Plan

If your group coverage ends, you may be eligible for an individual Coverage. Members should contact HPI's Customer Service department (at 1-888-212-1512) for information about eligibility for individual coverage under a conversion policy.

Section XV- CONVERSION AND CONTINUATION of the *Certificate of Coverage* (found in Section III of this benefit guide) provides further information about the steps to take to convert to individual coverage under a conversion policy. **Conversion to an individual policy must be made within 31 days of termination of your Group Coverage.**

When Coverage Terminates

Your HealthPlus PPO coverage will be terminated as described in your Certificate of Coverage if any of the following occurs:

- You enter active military service, except for temporary duty of 30 days or less.
- You are no longer eligible according to the Certificate of Coverage.
- The monthly subscription charge for benefits is not paid on time, subject to a 30-day grace period. Coverage will terminate effective on the last coverage date for which payment was received.
- You knowingly give HealthPlus false information at the time of enrollment or breach any terms or conditions of your Certificate of Coverage.
- You attempt to obtain services fraudulently.
- Others as listed in the Certificate of Coverage.

The list above is representative. For a complete list, refer to your Certificate of Coverage.

Your Preferred Provider Network

IN THIS SECTION:

Providers & Services
Finding Providers
Out-of-Network Providers
Care When Traveling

Selecting a Physician
Verifying a Provider
Switching Preferred Providers
If Your Provider Leaves HealthPlus

Preferred and Non-Preferred Providers/In-Network and Out-of-Network Services

Definitions for terms in italics can be found in the glossary at the end of this handbook section.

Your HealthPlus Insurance Company PPO plan allows you to receive covered services from *preferred providers* or *non-preferred providers*.

When you receive covered services from a HealthPlus Insurance Company preferred provider, your services are covered as *"in-network" benefits*. In-network benefits may require a flat dollar Copay for some services such as physician office visits or a percentage *Copay (coinsurance)* for other services such as hospital inpatient or outpatient services. You may be required to pay a *deductible* amount for some services before HealthPlus Insurance Company is responsible for any payments. Your financial responsibility for covered services received as in-network benefits is less than your financial responsibility would be for covered services received as *"out-of-network" benefits*.

When you receive covered services from non-preferred providers (physicians, hospitals or other providers that are not part of the HealthPlus Insurance Company PPO network) these will be paid as out-of-network benefits. Out-of-network benefits have a higher deductible and percent coinsurance than in-network benefits. In addition, when you see non-preferred providers, you may be billed for any excess charges; these are the differences between HealthPlus Insurance Company's allowed amount for a specific service and the non-preferred provider's charges for the service.

Please be aware that even if your preferred provider refers you to a non-preferred provider, you are responsible for the higher out-of-network deductible and coinsurance amounts and any *excess charges* billed by the non-preferred provider.

Please see your HealthPlus Insurance Company PPO *Certificate of Coverage* for the definition of terms in italics. Please see your *Schedule of Benefits* and applicable riders for specific Copay, coinsurance and deductible information.

Finding HealthPlus Insurance Company Preferred Providers

To make it easier to access care from a preferred provider, HealthPlus Insurance Company has developed an extensive network of providers in Michigan and across the country. Seeking or receiving covered services from a preferred provider entitles you and your family to an in-network benefit, which will generally result in lower costs.

Listings of all the preferred providers for your HealthPlus PPO plan are available at www.healthplus.org. Follow the three steps below:

1. Select Find a Doctor
2. Select HealthPlus PPO Plan
3. Select the area of the country where you want to locate a provider

You will be connected to the online directories for network preferred providers.

In Michigan

HealthPlus contracts with Cofinity (formerly PPOM), a health care provider network that includes physicians, hospitals and other outpatient care facilities. The Cofinity network includes more than 150 hospitals and over 2,500 physicians.

In Illinois

If you need care in Illinois, you may receive care from any provider in Health's Finest Network (HFN) and receive an in-network benefit. A list of HFN providers is available at www.healthplus.org.

In Indiana

In Indiana, you may receive in-network care from any provider in the Encore Health Network under your coverage. A list of Encore Health Network providers is available at www.healthplus.org.

In Ohio

In Ohio, you may receive in-network benefit care from any provider in the Emerald Health Network under your coverage. A list of Emerald Health Network providers is available at www.healthplus.org.

Outside of Michigan, Illinois, Indiana and Ohio

If you need care in the United States outside of Michigan, Illinois, Indiana or Ohio, you may see or receive care from any provider in the First Health Network and receive an in-network benefit under your coverage. A list of First Health Network providers is available at www.healthplus.org.

Using an Out-of-Network Provider

As a HealthPlus PPO member, you may receive care from any provider you choose. However, if you choose to receive health care from a non-preferred provider, you will receive out-of-network coverage benefits and you will be responsible for paying higher Copays for many services and higher coinsurance and deductibles on many plans. Please refer to your schedule of benefits for the details about your out-of-network benefits.

Seeking Care When Traveling

If you need non-emergency medical care when traveling anywhere within the United States, you may call GlobalCare at the number listed on the back of your ID card. A GlobalCare representative will provide directions to the nearest preferred provider in the HealthPlus PPO network. Receiving covered services from the provider you are directed to by GlobalCare will entitle you and your family to have the services covered as in-network benefits.

If you have a serious medical emergency that you feel is life threatening, go immediately to the nearest emergency room or call 911. As indicated on the back of your ID card, you must contact HealthPlus within 24 hours of an emergency hospital admission.

Please do not use emergency room or urgent care facilities for any illness that could be treated by a physician during regular office hours.

Selecting a Physician

Under the HealthPlus PPO plan, you are not required to select a primary care physician (PCP). You are, however, encouraged to establish a strong doctor/patient relationship with a provider who can coordinate your care in routine, maintenance and emergency situations.

When you choose a provider, you may want to consider the following:

Professional Education and Experience

The training and experience that a particular physician has may enhance your overall medical experience.

Board Certification

A physician becomes board certified by completing specialty training and passing an examination that demonstrates having the skills necessary to provide care in that specialty. Most board certified physicians also have a broad knowledge of common medical problems.

Hospital Affiliation

A physician may be affiliated with one or more hospitals to treat patients. Being affiliated with a hospital means the physician can admit patients there. If you are in need of hospital services, please talk with your physician about his or her hospital affiliations or those hospitals where he or she admits patients.

Language Fluency

A physician/patient relationship is very personal. Consider choosing a physician who is able to speak to you in the language you prefer.

Office Hours

Seeing a physician during his or her office hours means coordinating those office hours with your home and work life. Physician office hours vary. You may wish to select a physician whose office hours best meet your schedule.

Verify Provider Status When Making Your First Appointment

When making appointments with HealthPlus PPO preferred providers, let the office staff know you are a HealthPlus PPO member, and always verify that the provider is still part of the HealthPlus preferred provider network (or is a member of the PPOM, HFN, IHN, Emerald Health Network or First Health Network).

While HealthPlus Insurance Company makes every effort to keep directories up to date with current preferred providers, there can be occasions when a provider has terminated his or her contract with HealthPlus Insurance Company and/or the other listed networks, yet still shows in the directory. Checking provider status before you receive services will ensure you receive in-network benefits for covered services. Remember, benefits are paid based on the status of the provider on the day services are received.

When you go to the provider's office for your appointment, be sure to show your HealthPlus PPO ID card, both front and back. Make sure the office staff understands that all claims are to go to HealthPlus Insurance Company at the address on the back of your ID card. You will also want to point out that certain services require Prior Authorization and that the telephone numbers to call for Prior Authorizations are also on the back of your ID card.

See the "Medical Prior Authorization" section of this handbook for more information on Prior Authorizations. Also see your Certificate of Coverage and Schedule of Benefits for details on coverage limitations when no prior authorization is obtained.

Switching Preferred Providers

You are able to see any preferred provider, without referral, and receive in-network benefits at any time during your membership in the HealthPlus PPO. If you change your treating physician, we encourage you to request a copy of your medical records from your current physician and have it delivered to your new treating physician.

When choosing a new physician, always verify that he or she still participates in the HealthPlus PPO preferred provider Network (or is a member of the PPOM, HFN, Encore Health Network, Emerald Health Network or First Health Network) when calling for your appointment.

If Your Provider Leaves HealthPlus

From time to time a preferred provider may drop out of the HealthPlus PPO Network. This can occur for a number of reasons, such as if the provider is moving out of the area. As a result, HealthPlus Insurance Company cannot guarantee that a given preferred provider will be available to treat you during your entire term of coverage.

If your provider notifies you that he or she will no longer be in the HealthPlus PPO Network, contact the Customer Service Department at 1-888-212-1512 as soon as possible. A Customer Service Representative will help you find and select a different preferred provider so that you can continue to receive in-network benefits.

If you are in an ongoing course of treatment with a physician who is leaving the HealthPlus PPO Network, you may be able to continue to receive in-network benefits while receiving covered care from this provider for a period of time if:

- a. the provider is not leaving HealthPlus Insurance Company's PPO network because of failing to meet HealthPlus Insurance Company's quality standards or based on fraudulent conduct;
- b. the provider is still available to continue treating members;
- c. the continuation period is approved by HealthPlus Insurance Company;
- d. the provider agrees to continue to meet HealthPlus Insurance Company's quality standards and comply with HealthPlus Insurance Company's policies and procedures; and
- e. the provider agrees to accept, as payment in full, reimbursement from HealthPlus Insurance Company at the rates applicable prior to the provider's termination.

Treatment with the provider will continue, as applicable:

- for up to 90 days after the member receives notice that the provider is leaving HealthPlus Insurance Company's PPO network;
- through the second and third trimester of a pregnancy and through the completion of post-partum care; or
- in the case of a member with a terminal illness, through the remainder of the member's life for treatment related to the terminal illness.

Covered Services

IN THIS SECTION:

Emergency Care
Urgent Care
Preventive Care
Childhood Immunizations
Adult Immunizations
Keeping Children Healthy

Keeping Adults Healthy
“Well Woman” Services
Diagnostic Services
Other Services
Added Service with Benefit Rider

Emergency Care

If you have a serious medical emergency that you feel is life threatening, go immediately to the nearest emergency room or call 911. Your HealthPlus PPO plan covers you for emergency care. Your level of coverage will depend on whether you see a HealthPlus preferred provider or a non-preferred provider. Please check your Schedule of Benefits for specific emergency care benefit information.

HealthPlus PPO preferred provider hospitals should bill HealthPlus Insurance Company directly for emergency services. Like physician office visits, emergency services may be subject to a Copay. Please refer to your Schedule of Benefits or HealthPlus PPO ID card for information about your emergency room Copay responsibility.

There is no emergency room Copay if you are admitted to the hospital from the emergency room. If you are admitted to the hospital from the emergency room, you (or your representative) need to contact HealthPlus Insurance Company within 24 hours of the admission.

If you receive emergency services from a non-preferred provider, you may have to pay for the services and then submit a claim to HealthPlus Insurance Company for reimbursement.

Please see the “Requesting Reimbursement” section of this handbook for information on how to submit claims for reimbursement.

Urgent Care

Not all illnesses or injuries occur during your physician’s regular office hours. Urgent care centers offer treatment for minor injuries and illnesses such as sprains, flu or strep throat when your physician’s office is closed or he or she cannot see you quickly. For this reason HealthPlus Insurance Company contracts with many urgent care centers or after hour clinics. A list of preferred provider urgent care centers is included in the HealthPlus PPO Provider Directory, which you can access from our Web site at www.healthplus.org. You usually have a Copay for urgent care services, but this Copay is generally lower than that for emergency room services. When you need medical care immediately but don’t need emergency services, an urgent care or after hours clinic may be a convenient and economical option. Please see your Schedule of Benefits or HealthPlus PPO ID card for information about your urgent care Copay.

Routine Preventive Care

At HealthPlus Insurance Company we are committed to helping our members stay healthy by providing coverage for regular check-ups, routine screening services and routine immunizations. Covered preventive services, including immunizations, vary by member age and gender. The age of first screening or immunization and frequency of screenings or immunizations are listed below. Covered preventive services are not subject to member deductibles but may be subject to office visit Copay. Refer to your Schedule of Benefits for coverage details.

The immunizations and screenings listed below are covered as preventive services because they apply to the majority of the population. You should always discuss the need for such services with your physician. If you have health risks or a chronic condition, you should talk to your physician about tests and screenings appropriate for your situation. If you require more frequent screenings or additional tests and/or immunizations because of your health status, and the services are covered under your PPO plan, your deductible and coinsurance will apply. Refer to your Schedule of Benefits for details about your benefits and coverage.

Preventive Services: Covered Childhood Immunizations

Childhood immunizations are covered through the age of 18. Review childhood immunization needs with your child's physician or pediatrician. (See immunization chart, pages 9-10.)

Preventive Services: Covered Adult Immunizations

Flu shots are recommended for adults 50 years of age and older. They also are recommended for anyone at risk of complications from the flu. You and your physician can best determine if you need an annual flu shot. An annual flu shot is a covered preventive service for adults.

The pneumonia vaccine can prevent pneumonia and other related infections. It is usually given only once in a lifetime and is recommended at age 65 with a booster after six years, if needed. Discuss your need for this vaccine with your physician. He or she may recommend you get this vaccine before age 65 if you have certain chronic conditions such as bronchitis or emphysema, heart failure or diabetes; are a transplant recipient; or have a condition that weakens your immune system. The pneumonia vaccine is a covered preventive service for members 65 and older and others who have a medical need before the age of 65.

Tetanus-diphtheria boosters should be given at age 25 and then once every 10 years. This is a covered preventive service for adults once every 10 years and/or if injured.

Preventive Services: Keeping Children Healthy

At HealthPlus, we want to help you keep your children healthy. Your PPO plan includes Well Baby and Well Child physician visits and associated health screenings as covered preventive services. A specific number of Well Baby or Well Child visits are covered per benefit year from newborn through age 17 at 100 percent, as are several routine lab services associated with these visits. An office visit Copay may apply to any additional visits. Please refer to your Schedule of Benefits for detailed coverage information.

Well Baby and Well Child Physician Visits:

- Seven visits per benefit year through age 12 months.
- Six visits per benefit year for ages 13 through 23 months.
- Three visits per benefit year for ages 24 through 47 months.
- One visit per benefit year for ages 4 years through 17 years.

Childhood Screenings:

- **Hemoglobin/hemocrit** – once before age 1, and once between ages 11 and 17.
- **Lead testing** – infants/early childhood (discuss risk factors with your physician – not all children require lead testing).
- **Urinalysis** – once at age 5, and once between ages 11 and 17.

Childhood Immunizations		
Immunization	Prevention of	Number of Doses and Age Range
DTaP/Td	Prevention of diphtheria, tetanus, pertussis	<ul style="list-style-type: none"> • Recommended at 2, 4 and 6 months • Recommended between 15 and 18 months • Recommended between 4 and 6 years • Recommended between 11 and 16 years
IPV	Prevention of polio	<ul style="list-style-type: none"> • Recommended at 2 and 4 months and then between 6 and 18 months • Recommended between 4 and 6 years
MMR	Prevention of measles, mumps and rubella	<ul style="list-style-type: none"> • Recommended between 12 and 15 months • Recommended between 4 and 6 years OR between 11 and 12 years
Varicella	Prevention of chicken pox	<ul style="list-style-type: none"> • Recommended between 12 and 18 months (unless positive history or chicken pox) • Recommended at age 11 or 12 (if no prior immunization or history of chick pox)
Hib	Prevention of haemophilus influenza type b	<ul style="list-style-type: none"> • Recommended at 2, 4 and 6 months • Recommended between 12 and 18 months

Hepatitis B	Prevention of hepatitis B	<ul style="list-style-type: none"> • Recommended at birth, between 1 and 4 months and again between 6 and 18 months • Recommended at age 11 and 12 years if not received earlier
Pneumococcal Conjugate	Prevention of pneumonia	<ul style="list-style-type: none"> • Recommended at 2, 4 and 6 months and again between 12 and 15 months
Meningococcal (optional)	Prevention of bacterial meningitis	<ul style="list-style-type: none"> • Recommend one dose at 16-18 years for college freshmen
Flu Shot	Prevention of flu	<ul style="list-style-type: none"> • Recommended between 6 and 12 months • Recommended between 12 and 23 months

Please review all childhood immunization needs with your child's physician.

Preventive Services: Keeping Adults Healthy

At HealthPlus, we believe a routine health maintenance exam is one way to help keep our members healthy. During this visit to your physician you can discuss diet, exercise, medications, smoking cessation (if required) and preventive screening tests you may need based on your age and gender. Your HealthPlus PPO plan covers one health maintenance exam per benefit year as a preventive service at 100 percent.

In addition to the health maintenance exam, your HealthPlus PPO plan covers the following screening tests at 100 percent (office visit Copay may apply) as long as you meet the age and frequency requirements. Refer to your Schedule of Benefits for coverage specifics. If you have these tests more frequently than noted below or start having them before the "beginning age" shown, they remain covered services, but your deductible and member coinsurance will apply. Consult with your physician about when it is appropriate for you to have any of the screening tests listed.

Colorectal Cancer Screenings

Early detection of colon cancer improves chances of a good recovery. Routine colon cancer screening begins at age 50. There are several tests that can detect colon cancer.

- Fecal occult blood test – uses three stool samples collected over three days to test for traces of blood in the stool.
- Sigmoidoscopy and colonoscopy – exams of the rectum and colon, which use a flexible, lighted tube to check for polyps.
- Double contrast barium enema – you are given an enema, and then X-rays are taken of your colon to check for polyps or other indications of colon cancer.

Colon cancer screening frequency varies based on the type of test. If you and your physician determine the fecal occult blood test is best for you, this is a covered preventive service once per benefit year.

A sigmoidoscopy or double contrast barium enema would be a covered preventive service once every 5 years. A colonoscopy would be a covered preventive service once every 10 years.

Cholesterol screening

If you have high blood cholesterol levels, you have an increased risk of heart disease. Discuss your risk factors for heart disease with your physician. Cholesterol screening is a covered preventive service once every benefit year beginning at age 18.

Diabetes screening

Diabetes can lead to complications including heart disease, kidney disease and even amputation of limbs, if left untreated. Diabetes screening is a covered preventive service once every benefit year beginning at age 18.

Prostate Cancer Screening For Men Only

As part of their health maintenance exam, men should have a prostate exam. A routine PSA test is a covered preventive service once per benefit year beginning at age 45.

Well Woman Services

At HealthPlus, we are committed to helping our members stay well by providing coverage for preventive care. Routine care for women is no exception. With the HealthPlus PPO you are free to choose from a broad network of physicians, including Family Practice, General Practice, Internal Medicine and Obstetrician-Gynecologists, for your annual well-woman exam and routine obstetrical services.

In addition to the preventive services described above, the following are covered preventive services for our women members. While all services are covered at 100 percent when the age and frequency requirements are met, an office visit Copay may apply to some services. Please refer to your Schedule of Benefits for coverage details.

Gynecological Examination and Pap Test

A Pap test is still the best method for detecting cervical cancer early. While an abnormal Pap test can be a sign of cervical cancer, it does not always mean you have cancer. You and your physician should determine how frequently you need a Pap test. It is most often recommended that women get a Pap test at least once every three years after becoming sexually active, but they should have their first one no later than age 21. One gynecological exam and Pap test are covered as a preventive service once per benefit year, beginning at age 18 or younger if required.

Breast Cancer Screening Mammography

A mammogram is an X-ray of the breast that is able to detect tumors too small to feel. As a preventive service, your HealthPlus PPO plan covers one breast cancer screening mammogram between the ages of 35 and 40 and one per benefit year, beginning at age 40.

Chlamydia Screening

Chlamydia is a sexually transmitted disease (STD) that often has no symptoms. Because you can give STDs to your partner or your unborn baby, it is important to be screened for chlamydia if you are sexually active. One chlamydia screening per benefit year is covered as a preventive service for women beginning at age 18 or younger if required.

Members should note that preventive diagnostic screenings furnished more than once a benefit year (except as otherwise noted for Well-Baby and lead testing of children) are not deemed to be Preventive Services, and the member will be responsible for paying any applicable Copay and deductible for such services.

Routine Prenatal Physician Visits

Physician visits for routine prenatal care are covered at 100 percent after the first visit; an office visit Copay may apply. Routine visits to a nurse-midwife are covered if the nurse-midwife is associated with a HealthPlus PPO preferred provider Obstetrician or clinic and bills us to indicate such a relationship.

Diagnostic services related to pregnancy are covered services; Copays, deductibles and coinsurance will apply to these services as they would any other diagnostic service.

Diagnostic Services: Laboratory and Pathology Tests

Effective April 1, 2011, HealthPlus has contracted with Joint Venture Hospital Laboratories (JVHL) as the preferred laboratory vendor for outpatient laboratory services. JVHL is a consortium of hospital owned laboratories throughout the State of Michigan. JVHL laboratory sites are located within hospital outpatient sites, as well as Patient Service Center draw sites, located throughout the community.

With the addition of JVHL, HealthPlus providers and members now have more laboratory choices than ever before. Members can continue to utilize their favorite Quest location or use a preferred JVHL site, anywhere in Michigan.

To obtain a complete list of participating JVHL and Quest Patient Service Center draw sites, please consult the HealthPlus website at www.healthplus.org. Please consult your Schedule of Benefits for details of your specific coverage.

Other Services

Your HealthPlus PPO plan covers a variety of health services in addition to those discussed in this handbook. These include:

- Durable medical equipment
- Family planning services
- Inpatient and outpatient hospital services
- Mental health and substance abuse services
- Short-term outpatient physical, speech and occupational therapy
- Skilled nursing facility and hospice services

Your Schedule of Benefits, Certificate of Coverage and any applicable riders have a complete list of covered services, limitations and exclusions. You must read these documents completely to fully understand what services are covered for you

and your family. Your Schedule of Benefits and any applicable benefit rider explains in detail your costs for services including any Copays, deductibles and member coinsurance.

Services Added to Plan with a Benefit Rider

The following are covered services only if your employer has added the applicable benefit rider(s) to your PPO Plan. Applicable riders should be read to understand your benefits and any Copays.

- Prescription drugs (See details about the HealthPlus PPO prescription drug benefit management practices below)
- Chiropractic services
- Hearing aid(s) and testing
- Private duty home health nursing

Refer to your Schedule of Benefits; it will indicate if your employer added any of these benefits to your plan. If your Schedule of Benefits indicates you have any of the following benefits, the applicable rider was included with your member materials.

NOTES: _____

Prescription Drug Coverage

IN THIS SECTION:

Participating Pharmacies
Prescription Copays
Drug Formulary
Generic Drugs
Medication Authorization

Step Therapy
Injectable Medications
90 Day Medication Programs
Dentist Prescriptions

Participating Pharmacies

If your employer has purchased a prescription drug rider, you may fill your prescriptions at any participating HealthPlus Insurance Company pharmacy. The HealthPlus Insurance Company pharmacy network includes most major pharmacy chains and many smaller, independently owned pharmacies. A list of participating pharmacies is included in your PPO provider directory, or you may do a search by zip code at www.healthplus.org.

When you go to a participating pharmacy, show your HealthPlus Insurance Company PPO ID card to the pharmacist. **Please remember that every person in your family has his or her own ID card, so you have to use the correct card for the correct family member for each prescription.**

If you choose to frequent a non-participating pharmacy, you must pay for the prescription and submit a request for reimbursement to HealthPlus Insurance Company (within one year of the prescription fill date). If the claim meets requirements for coverage, HealthPlus Insurance Company will reimburse your claim at standard HealthPlus pharmacy rates (not the amount you paid). You will be responsible for the difference in cost between HealthPlus Insurance Company rates and the amount you paid to the pharmacy, plus any applicable Copays.

Prescription Copays

Prescription Copays vary based on the rider purchased by the employer. All medications, including medications with step protocols or prior authorization requirements, fall into specific tiers or levels. The tier or level of a medication determines your Copay for that drug.

If your employer purchased a two-tier prescription drug rider:

Tier	Drug Description	Copay
Tier 1	Generic drugs	Lower Copay
Tier 2	Formulary (preferred) and non-formulary (non-preferred) brand drugs	Higher Copay

If your employer purchased a three-tier prescription drug rider:

Tier	Drug Description	Copay
Tier 1	Generic drugs	Lower Copay
Tier 2	Formulary (preferred) brand drugs	Lower Copay
Tier 3	Non- formulary (non-preferred) brand drugs	Highest Copay

The information on your ID card includes your specific Copays for prescription drugs.

Drug Formulary

HealthPlus Insurance Company uses a drug formulary, which is a “preferred” list of drugs that contains generic and brand drugs. The drugs on the formulary are considered the best choices based on safety, effectiveness, uniqueness and reasonableness of cost. As new drugs become available, the selection of drugs on the formulary may change in order to

contain the drugs required to meet drug therapy needs. The drug formulary is developed with the help of practicing physicians and pharmacists to help ensure that the list contains high quality and cost-effective medications.

HealthPlus Insurance Company covers most FDA-approved medications. Medications that are not listed on the formulary may still be a covered benefit, subject to the applicable benefit limitations and exclusions of your coverage and other HealthPlus programs, such as Prior Authorization and step therapy. Based on the rider purchased by the employer, you may be responsible for a higher Copay for brand drugs that are not on the formulary.

For the most up to date listing of the formulary, go to the Web site at www.healthplus.org and select the "Member" tab. Here you may review the formulary or search for a drug based on your specific rider. You also may contact HealthPlus Customer Service for a printed copy of the formulary.

Generic Drugs

A generic drug is a drug that contains the same active ingredients in the same amounts as a brand drug. After the patent expires on a brand drug, other companies can make the same drug in a generic version for a much lower cost. Just like brand drugs, generic drugs must be approved by the Food and Drug Administration (FDA), and are as safe and effective as the brand drug.

When a generic drug is available, only the cost of the generic drug is covered (not the brand). Your pharmacy will automatically fill your prescription with the generic drug.

If you or your physician asks for the brand drug instead, you are responsible for the difference in cost between the brand and generic drug plus your usual Copay. *Exception: If there is a valid medically necessary reason for you to receive the brand name drug instead of the generic drug, your physician may submit a request for Prior Authorization for the brand name drug, including documentation of medical necessity, for review and determination of coverage by HealthPlus Insurance Company.*

Prior Authorization for Medications

HealthPlus Insurance Company requires Prior Authorization for certain medications, based on clinical, safety or cost issues. Prior authorization means that the medication is subject to pre-approval to be eligible for coverage; you must meet certain criteria in order for the drug to be covered. In addition, brand name drugs that have a generic equivalent may require Prior Authorization, or the quantity of a medication may be limited with Prior Authorization required for greater quantities. Your physician must submit the request for Prior Authorization to HealthPlus by contacting the HealthPlus Pharmacy Department.

If your physician submits a request for Prior Authorization, and you meet Prior Authorization criteria for the medication, the drug is a covered benefit; you pay a Copay for that drug, based on the formulary tier or level of that drug.

If your physician does not submit a request for Prior Authorization or if your physician submits a request for Prior Authorization and you do not meet the established Prior Authorization criteria for that medication, the medication is not a covered benefit.

Step Therapy

HealthPlus Insurance Company uses step therapy for certain medications, which means that you must try certain "first step" drugs before other "second step" drugs are covered. In most cases, first step drugs are cost-effective generic medications that are used to treat your condition. Second step medications are generally more expensive brand drugs that are used to treat the same condition.

Step therapy is automated in the prescription claims processing system. If your pharmacy submits a claim for a second step drug, and you have already tried and failed the first step drug(s), the system will approve the claim for the second step drug. You pay a Copay for that drug, based on the formulary tier or level of that drug.

If you do not meet step therapy requirements, which means that you have not tried the first step drug(s), the medication is not a covered benefit.

Injectable Medications

In general, injectable medications that are self-injected by the patient are included in the prescription drug benefit. Examples include insulin, Epi-Pen and Imitrex. Your Copay is based on the tier or level of the drug.

Medications that are injected or infused at the doctor's office (e.g., Depo-Provera) are a medical benefit and are subject to applicable deductibles and coinsurance. Your physician may obtain these medications from his or her own supplier or from the HealthPlus specialty pharmacy vendors; these medications are not covered at retail pharmacies or through mail order and are not eligible for reimbursement through the prescription drug benefit.

90-Day Medication Programs

HealthPlus Insurance Company offers two options for filling prescriptions in a 90-day supply, with Copay savings:

Local Pharmacies

“Ask for 90 Rx”-This program allows you to receive up to a 90-day supply of certain medications from retail pharmacies that participate in the program, with Copay savings. For more information, go to www.healthplus.org for a Frequently Asked Questions flyer and a list of retail pharmacies that participate in the **Ask for 90 Rx** program. Or, you may contact the HealthPlus Customer Service Department for more information.

If you choose to fill 90-day prescriptions through a pharmacy that does not participate in the **Ask for 90 Rx** program, the prescriptions are not covered and are not eligible for reimbursement. (You may fill prescriptions for up to a 34-day supply at a non-participating pharmacy; you must submit the receipt for reimbursement and are responsible for additional costs as described above.)

Mail Service Program

You are eligible for the HealthPlus mail service program through Express Scripts. You may receive up to a 90-day supply of certain medications, save money on Copays, and have your prescriptions delivered to your home with no shipping costs. For more information about mail service prescriptions, go to www.healthplus.org, or contact the HealthPlus Customer Service Department.

IMPORTANT: Express Scripts is the exclusive mail service provider for HealthPlus. If you choose to fill prescriptions through another mail service provider, the prescriptions are not covered and are not eligible for reimbursement.

Copay savings from both of these programs are the same. You pay the same Copay for a 90-day supply at an **Ask for 90 Rx** retail pharmacy as you do at Express Scripts. Please refer to your Prescription Drug Rider for more information about your specific Copays.

Most maintenance medications are covered through the 90-day programs. Compounded medications and injectable medications, with the exception of insulin, glucagon, Epi-Pen and Imitrex, are not covered through the 90-day programs.

Prescriptions from Dentists

HealthPlus provides limited coverage for prescriptions written by dentists. The list of covered medications, called the Dental Formulary, includes several antibiotics and pain medications, but is not intended to include all medications that may be prescribed by a dentist.

If your dentist prescribes a medication that is not on the Dental Formulary, it is not covered and is not eligible for reimbursement.

For a copy of the Dental Formulary, go to www.healthplus.org or contact the HealthPlus Customer Service Department.

Medical Prior Authorization

IN THIS SECTION:

How to Get a Prior Authorization Services Requiring Prior Authorization

How to Obtain Prior Authorization

You are required to obtain Prior Authorization for medical services that are planned or scheduled ahead of time. A complete list of services that require Prior Authorization is available in the Certificate of Coverage, at www.healthplus.org or may be obtained by calling Customer Service at 1-888-212-1512.

If Prior Authorization is required, it must be obtained from HealthPlus Insurance Company or its designee at least 5 days before the services are received. If you do not obtain Prior Authorization and the service is not medically necessary, you will be responsible for the entire cost of the service. If HealthPlus Insurance Company or its designee determines that the service was medically necessary and a Prior Authorization was not obtained, you will be charged a penalty. The amount of penalty is described in your Schedule of Benefits.

The amounts paid due to failure to obtain Prior Authorization will not apply to your deductible or out of pocket maximum as described in your Schedule of Benefits.

Phone numbers for obtaining Prior Authorization are on the back of your ID card. You should always check with HealthPlus Insurance Company to be sure that planned services have been Prior Authorized before you have the service. This will help you avoid unplanned expenses.

Services Requiring Prior Authorization

Your plan may require Prior Authorization for the services listed below. These services must also meet medical necessity criteria to be covered services:

A. Consultations/Procedures

1. Plastic, cosmetic or reconstructive surgery, including, but not limited to, surgery of the skin, botox injections, heat, cold or chemical treatment of acne, removal of skin tags, lifts or removal of excess skin.
2. Heat, cold or chemical treatment of acne
3. Surgery of the jaw or gums and jaw reconstruction
4. Breast enlargement, reduction, adjustment to make breasts of equal size or removal of breast implants
5. Weight loss(bariatric) surgery
6. Surgical treatments for snoring and sleep apnea
7. Transplant and evaluations for transplant
8. Autologous chondrocyte knee transplant (harvesting from or transplanting cartilage cells in the knee)
9. Bone anchored hearing aid
10. Services of an anesthesiologist for outpatient dental procedures
11. Genetic counseling, testing and screening
12. Covered infertility services
13. Varicose vein treatments
14. Robotic Image Guided Linear Accelerator (e.g. Cyberknife, Novalis TX, Accesse). (This type of equipment is sometimes used for cancer and other types of surgery. Please review with your physician/surgeon and be sure the use has been authorized by HPI so you have coverage)
15. Clinical trials and associated routine medical care (inpatient, outpatient, or physician office directed)

B. Inpatient Care

1. Elective (non-emergent) admissions, inpatient skilled nursing, sub acute, long-term acute and rehabilitation care
2. Mental health and substance abuse admissions, including detoxification, residential day treatment (partial hospitalization) and intensive outpatient/intermediate care
3. Skilled nursing facility care
4. Inpatient hospice care

C. Outpatient Services

1. Synagis, an injectable vaccine for the prevention of respiratory syncytial virus (RSV) in infants and children at risk
2. Specialty injectable medications such as growth hormones, or injectable drugs for rheumatoid arthritis or multiple sclerosis given at physician office or outpatient facility
3. Outpatient pulmonary rehabilitation

4. Psychological testing for Attention Deficity Hyperactiviey Disorder (ADHD), Attention Deficit Disorder (ADD) and Oppositional Defiant Disorder (ODD)
5. Prosthetics and orthotics
6. Outpatient mental health and substance abuse services beyond 30 visits (or specific limit on your Schedule of Benefits)
7. Home health services beyond 30 visits per benefit year
8. Residential hospice or home hospice care beyond 180 days
9. Non-emergency ambulance transportation between health care facilities

D. Durable Medical Equipment (DME)

1. The following DME items always require Prior Authorization
 - a. Bone growth (osteogenic) stimulators, electric or ultrasound
 - b. CPAP or BiPAP machines for snoring or sleep apnea. Be sure your physicians contacts HealthPlus to reauthorize the need for a machine every three months
 - c. Custom-made compression stockings
 - d. Insulin pumps
2. DME items with a cost of \$3000 or more always require prior authorization. Some examples of such DME include:
 - a. Chair-lift mechanism
 - b. Chest Compression Vest and Life Vests (wearable automatic cardiac defibrillators)
 - c. Power Wheel Chairs and Power Operated Vehicles
 - d. Speech Generating Machines and Ventilators

NOTE: If a home health agency is ordering DME for you, please be sure they are getting the proper prior authorizations or the items may not be covered

E. Imaging Services, Diagnostic and or Therapeutic Services

1. Nuclear Studies (such as thyroid and bone scans) and Cardio Nuclear Studies (such as nuclear stress tests)
2. Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA)
3. Computerized Axial Tomography (CAT scan), Computerized Tomography (CT), and Computerized Tomography Angiography (CTA) and Positron Emission Tomography (PET scan)
4. Virtual studies such as virtual colonoscopy and capsule endoscopy studies

Without obtaining Prior Authorization from HealthPlus Insurance Company (including if your treating physician refuses to comply with HealthPlus Insurance Company’s Prior Authorization requirements even after HealthPlus Insurance Company has contacted the physician), high technology radiological services are not covered.

Please see the back of your HealthPlus PPO ID card for the telephone number to call for Prior Authorization of these services. If you have any difficulties getting your Prior Authorization or if your physician refuses to ask for the required Prior Authorization, contact HealthPlus Customer Service at 1-888-212-1512.

Other Programs

IN THIS SECTION:

- Case Management**
- Disease Management**
- Health & Lifestyle**

Case Management

A primary objective of HealthPlus Insurance Company is to provide access to quality health care at a reasonable cost. The HealthPlus Case Management Program helps our members receive care that is both medically necessary and cost-efficient. At HealthPlus, qualified physicians and nurses administer case management. Typically, a HealthPlus nurse case manager works closely with you to coordinate your care among physicians and other health professionals. These physicians and nurses use nationally accepted guidelines that are annually reviewed by a committee of local physicians and are tailored to meet individual member needs.

Case Management provides our members with support for special and ongoing medical needs. Case management services are available to any HealthPlus member, but this service is particularly helpful to those experiencing a severe health crisis such as an accident or unplanned admission to a hospital for an illness. To request Case Management services, contact Customer Service at 1-888-212-1512.

Disease Management

HealthPlus Insurance Company provides disease management programs for members with the following chronic conditions:

- Asthma
- Cardiovascular Conditions
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Heart failure

For members who participate in the HealthPlus disease management programs, support from HealthPlus may include:

- Welcome calls
- Introductory packet
- Health risk appraisal
- Care reminder calls and letters
- Educational materials
- General health and condition specific assessments
- Newsletters
- Quality of life survey
- Screening for depression
- Member Satisfaction Survey

Health and Lifestyle Management

HealthPlus is always looking for innovative ways to show our members that we appreciate them for choosing us.

HealthQuest Perks provides valuable discounts. For example:

Weight Watchers

HealthPlus and Weight Watchers have joined forces to bring you phenomenally low rates on three proven weight management plans: Weight Watchers local meeting vouchers, Weight Watchers Online subscription and the Weight Watchers At Home kit. As an added incentive, HealthPlus will reward you for participating in the weight management offering of your choice! Simply complete 10 weeks of your Weight Watchers plan and HealthPlus will reimburse half of your cost (a maximum reimbursement of \$83). Call 1-866-252-3007.

Jenny Craig

Are you ready to join Jenny and lose those unwanted pounds? HealthPlus and Jenny Craig have teamed up to assist you. HealthQuest Perks now offers a Jenny Craig discount just for being a valued HealthPlus member. Call 1-877-JENNY70.

Edgepark Medical Supply

Edgepark Medical Supply offers discounted costs on products you may need including blood pressure cuffs, pedometers and weight scales. Call 1-800-321-0591.

Hurley Health & Fitness

Members can take advantage of a \$29 Joining Fee (\$249 value) and half-off dues for the first three months. This offer cannot be combined with any other offers.

Snap Fitness

HealthPlus members can now enjoy free enrollment plus 10% off monthly dues at Snap Fitness Centers nationwide. Call 1-877-474-5422.

Laptop Lunches

Laptop Lunches are famous for being a portion-controlled, waste-free way to pack a lunch from home. HealthPlus members can receive 20% off their orders at www.laptoplunches.com. Use the coupon code "healthplus" upon checkout. These laptop lunches are great for adults and children alike!

EyeMed Vision Care

Save up to 35 percent on frames and lenses, and 15 percent on conventional contact lenses. Simply visit the EyeMed Vision Care provider of your choice and present your HealthPlus ID. Discounted EyeMed Vision Care prices are automatically calculated. Call 1-866-559-5252.

Moosejaw

HealthPlus members can now receive a 10 percent discount off in-stock purchases at Moosejaw shops and online. Moosejaw, a Michiganbased retail store, offers everything from clothing, shoes and sports equipment to camping and hiking gear. Use the discount code: HEALTHQUEST to obtain the 10 percent HealthPlus member discount. Check them out on line or to find a shop near you (www.moosejaw.com). The following brands are excluded due to vendor agreements: Arc'Teryx, Bugaboo, Suunto, The North Face, Patagonia, Western Mountaineering and Yakima.

To learn more about HealthQuest Perks, log on to www.healthplus.org.

Requesting Reimbursement

IN THIS SECTION:

Submitting Claims
Explanation of Benefits

Submitting Claims

Whenever possible, you should wait to receive an Explanation of Benefits (EOB) document before paying the provider. When HealthPlus processes your claims for services rendered by a preferred or non-preferred provider, the EOB document is mailed to you to advise of any dollar amounts you are responsible for, such as, your Copays, deductibles and coinsurance. The EOB will break down the billing charges and indicate the payments and/or denials for non-covered services made to the provider by HealthPlus. However, should a provider request payment in full at the point of service, you may seek reimbursement from HealthPlus for covered services.

If you are seeking reimbursement for covered services (not including your Copays, deductibles or coinsurance) that you paid in full, or if you receive a bill, please complete an approved Request for Reimbursement form and send it, along with your original prescription or medical receipt, to HealthPlus within 90 days after the occurrence (or as soon as reasonably possible) to:

HealthPlus Insurance Company
Attn: Customer Service Department
P.O. Box 1700
Flint, MI 48501-1700

To obtain a Request for Reimbursement form, please contact the HealthPlus Customer Service Department at 1-888-212-1512 or visit our Web site at www.healthplus.org to print a copy.

Explanation of Benefits

An Explanation of Benefits (EOB) form is created whenever claims are submitted for you. This form will detail the charges billed, the allowable amount for the services rendered, any deductible, Copay or coinsurance applied to the allowed amount and any amount that would be the financial responsibility of the member to pay to the provider of services. The EOB will also keep track of charges applied to the member and/or family deductibles and out of pocket maximums for the current benefit year. You should keep all EOBs for your records.

Remember — this form is not a bill. The treating physician or facility will send any bill for charges that are a member's responsibility to the member.

Rights, Responsibilities, Regulations, Member Satisfaction

IN THIS SECTION:

**New Technology
Patient Bill of Rights
Privacy Notice
Janet's law
Member Rights & Responsibilities**

**Member Satisfaction
External Review
Grievance Process
Fraud & Abuse**

Benefit Interpretation and New Technology Evaluation

Medical technology is constantly advancing and improving. In keeping with our commitment to you, we strive to stay abreast of changes that affect and benefit your health care. HealthPlus Insurance Company has developed a process for evaluating new medical and behavioral procedures, medications and devices, along with new uses of existing technology. Our process begins with a review of information from several sources, including government regulatory agencies and published scientific findings. Appropriate health professionals are involved in the process. They decide whether to include new technologies or new uses for existing technologies in the benefits that HealthPlus Insurance Company offers its members. Should we make changes to our benefits, we will notify HealthPlus Insurance Company members and HealthPlus Insurance Company preferred providers, as appropriate.

Patient Bill of Rights

As a member of HealthPlus Insurance Company, you have certain rights as specified by a Michigan law, the Patient Bill of Rights. This notice is provided to you in order to explain those rights. The following are intended to assist you in understanding health coverage provided by HealthPlus Insurance Company:

1. HealthPlus PPO Certificate of Coverage

In order to provide a clear description of your new health care benefits, you are also provided a copy of the applicable HealthPlus Insurance Company Certificate of Coverage, Schedule of Benefits and any applicable rider(s). These documents contain a clear, complete and accurate description of the following:

Covered benefits, which may include prescription drug coverage, if applicable, with specifications regarding requirements for the use of generic drugs;

- a. An explanation of your financial responsibility, if any, for Copays, coinsurance, deductibles and any other description of emergency health coverage and benefits;
- b. Out-of-area coverage and benefits;
- c. Out-of-pocket expenses;
- d. An explanation of how to file a grievance.

2. Continuity of Treatment

If a preferred provider's participation terminates during a member's course of treatment by that provider, HealthPlus Insurance Company shall, depending upon the circumstances, do either of the following:

- a. Arrange for the continuation of treatment by that provider; or
- b. Assist the member in selecting a new provider to continue with treatment.

3. Intractable Pain

Intractable pain is a pain state where the cause of the pain cannot be removed or otherwise treated and for which, in the generally accepted practice of medicine, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts. If you believe that you may be experiencing intractable pain, we encourage you to talk with your treating physician about your condition. Your treating physician will evaluate and treat you or recommend that you see a specialist if he or she decides that is necessary. Physician and other services are covered in accordance with the terms of your applicable HealthPlus Insurance Company Certificate of Coverage, Schedule of Benefits and any applicable rider(s).

4. Additional Information

As a member of HealthPlus PPO, you have the right to request and receive additional information about HealthPlus Insurance Company. This includes:

a. Provider Information

You are entitled to receive a copy of the HealthPlus PPO Provider Directory, which provides you information concerning physicians and other providers who contract to provide services to HealthPlus PPO members. It contains:

- 1) Names, location, hospital affiliation and specialty (type of practice) of preferred physicians;
- 2) Designation of which physicians are accepting new patients; and
- 3) Listing of other contracting providers.

b. Physician Credentials

You are entitled to receive information concerning the professional credentials of participating physicians, including:

- 1) Degrees received;
- 2) Certification date, if applicable; and
- 3) Identification of the preferred facilities where the physician has privileges for any treatment, illness or procedure you require.

c. Physician Status/Discipline

We can provide you with information on how to contact the Michigan Department of Community Health. This State agency maintains records concerning licensed physicians.

d. Specific Benefits

You are entitled to information concerning any requirements, limitations, restrictions or exclusions including, but not limited to, information concerning the HealthPlus Insurance Company's drug formulary, as may be applicable by type of service, benefit or provider or, if applicable, by specific service, benefit or type of drug.

e. Financial Arrangements with Providers

You are entitled to summary information concerning the financial relationship between HealthPlus Insurance Company and any provider, including:

- 1) Whether a "fee-for-service" arrangement exists;
- 2) Whether a "capitation" arrangement exists; and
- 3) Whether HealthPlus Insurance Company's payment to providers is based upon cost, quality or patient satisfaction.

5. Whom To Contact

To receive information concerning any of the above topics, call the HealthPlus PPO Customer Service Department at 1-888-212-1512. Our Customer Service Department can help you understand how to file a grievance, as well as assist you with any other questions you may have about your HealthPlus Insurance Company coverage.

Privacy Notice

This notice describes how personal and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Information We Have

We receive enrollment information about you, which includes your date of birth, sex, identification number and other personal information. We also receive bills, physician reports and other information about your medical care.

Our Privacy Policy

We care about your privacy and we guard your information carefully. We are required to maintain the privacy of your information and to provide you with this notice of our legal duties and our privacy practices. Internally, we protect your oral, written and electronic information by requiring employees and others with access to such information to follow specific confidentiality and technology use procedures. We will not sell any information about you. Only people who have both the need and the legal right may see your information.

Disclosure of Information

Unless you give us a written authorization, we will only disclose your information for purposes of treatment, payment, business operations or when we are required by law to do so.

Treatment

We may disclose medical information about you for the purpose of coordinating your health care. For example, we may notify your personal doctor about treatment you receive in an emergency room.

Payment

We may use and disclose medical information about you so that the medical services you receive can be properly billed and paid for. For example, we may ask a hospital emergency department for details about your treatment before we pay the bill for your care.

Business Operations

We may need to use and disclose medical information about you in connection with our business operations with affiliated entities. For example, we may use medical information about you to review the quality of services you receive and to investigate fraud and abuse.

Health-Related Benefits and Services

We, or our agents, may contact you about other health-related benefits and services that may be of interest to you.

As Required By Law

We will release information about you when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, public health services, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety or in other kinds of emergencies.

Employer Plans

We will share only enrollment information or summary health information (or other information if required by law) with an employer or plan sponsor. However, we may share your personal and medical information with the employer or plan sponsor if you are a participant or dependent in a self-funded employer health plan and the employer has provided us with written assurances that the information will be kept confidential and will not be used for an improper purpose.

Authorizations

If you give us a written authorization to do so, we may use and disclose your personal information. If you give us a written authorization, you have the right to change your mind and revoke that authorization.

Copies of this Notice

You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to us to request a copy.

Changes To This Notice

We reserve the right to revise the Privacy Notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published in our member newsletter.

Other Laws and Regulations

HealthPlus must comply with all federal and state laws and regulations. Michigan law and other federal law may provide additional protection for your personal health information (e.g., HIV/AIDS, behavioral health and minors).

Your Right to Inspect and Copy

Upon written request, you have the right to inspect the information we have about you and to get copies of that information.

Your Right to Amend

If you feel that the information about you, which we have, is incorrect or incomplete, you may make a written request to us to amend that information. We may deny your request for certain limited reasons, but we must give you a written reason for our denial.

Your Right to a List of Disclosures

Upon written request, you have the right to receive a list of our disclosures of your information, except when you have authorized those disclosures or if the disclosures are made for treatment, payment or health care operations. We are not required to give you a list of disclosures made before April 14, 2003.

Your Right to Request Restrictions on Our Use or Disclosure of Information

If you do so in writing, you have the right to request restrictions on the information we may use or disclose about you. We are not required to agree to such requests.

Your Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain manner or at a certain location. Your request must be in writing. For example, you may ask that we contact you only at home or only at a certain address or only by mail.

How to Use Your Rights Under This Notice

If you want to use your rights under this notice, you may call us or write to us. If your request to us must be in writing, we will help you prepare your written request, if you wish.

Complaints and Communications to Us

If you want to exercise your right under this Notice or if you wish to communicate with us about privacy issues or if you wish to file a complaint, you may write to: Compliance and Privacy Official at 2050 S. Linden Road, Flint, Michigan, 48532 or call the Compliance Hotline at 1-800-345-9956. You will not be penalized for filing a complaint.

Complaints to the Federal Government

If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to: Office of the Secretary, Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint with the federal government.

When we refer to HealthPlus, we, or our, we mean HealthPlus of Michigan, Inc. and its affiliated entities, HealthPlus Partners, Inc., HealthPlus Options, Inc. and HealthPlus Insurance Company. We are affiliated entities as defined under the Health Insurance Portability and Accountability Act and related regulations ("HIPAA") and we share information among ourselves as appropriate. When we refer to you, we mean a member of HealthPlus of Michigan, Inc. and its affiliated entities, HealthPlus Partners, Inc., HealthPlus Options, Inc. and HealthPlus Insurance Company.

Janet's Law

The "Women's Health & Cancer Rights Act of 1998" is a federal law, also known as "Janet's Law." Your HealthPlus Insurance Company Certificate of Coverage and Schedule of Benefits explains the medical and surgical benefits in connection with a mastectomy as provided by this Act. If you have had a mastectomy and wish to elect breast reconstruction in connection with the mastectomy, please note that the following coverage is available to you:

- 1) Reconstruction of the breast on which the mastectomy has been performed;
- 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- 3) Prostheses, if medically necessary; and
- 4) Care for physical complications from all stages of the mastectomy, including lymph edemas.

The described coverage must be provided in a manner determined in consultation with you and your attending physician. Finally, please note that the described coverage is subject to any applicable annual deductibles, coinsurance provisions and Copays as provided in your Certificate of Coverage, Schedule of Benefits and any applicable benefit rider(s). If you have any questions, please call the HealthPlus PPO Customer Service Department at 1-888-212-1512.

Member Rights and Responsibilities

HealthPlus Insurance Company is committed to treating its members in a manner that respects their rights and addresses their responsibility for cooperating with HealthPlus PPO staff and preferred providers. HealthPlus Insurance Company recognizes the following rights of its members:

- To be treated with respect and to have their dignity and personal privacy recognized.
- To receive advice or assistance in a prompt, courteous and responsible manner.
- To receive information about HealthPlus PPO, their rights and responsibilities as a member, their health care benefits and the participating physicians and other preferred health care providers from whom they receive care.
- To express a complaint about HealthPlus PPO or about care they have received and to receive a response to the complaint within a reasonable period of time.

- To participate in decisions involving their health care.
- To participate in a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To refuse treatment and to be informed of the probable consequences of their actions.
- To be assured of confidential health records except when disclosure is required by law or permitted in writing by them. With adequate notice, they have the right to review their medical records with their treating physician.
- To make recommendations regarding the member rights and responsibilities policy.

HealthPlus Insurance Company recognizes the following responsibilities of its members:

- To treat all HealthPlus Insurance Company and preferred provider personnel and other members respectfully and courteously.
- To keep scheduled appointments or give adequate notice of delay or cancellation.
- To provide information that HealthPlus Insurance Company, participating physicians and other preferred health care providers might need in order to provide health care benefits and to care for them.
- To be honest and complete when providing information to the treatment staff, including a complete and accurate medical history and any complications that may arise in the course of treatment.
- To follow the recommendations and advice they agreed to with the treatment staff concerning their care and to consider the potential consequences if they refuse to comply.
- To participate in understanding their health problems and developing mutually agreed-upon treatment goals.
- To express their opinions, concerns or complaints in a constructive manner to the appropriate people within HealthPlus or a preferred provider network.

This statement of member rights and responsibilities in no way modifies the benefit coverage and limitations provided by the applicable HealthPlus PPO Certificate of Coverage, Schedule of Benefits and applicable rider(s), if any.

Member Satisfaction Plan

Because your satisfaction is one of the main goals at HealthPlus Insurance Company, we have established a Member Satisfaction Plan. The Member Satisfaction Plan has two main purposes. The first purpose is to see that you receive the answers to any questions you have about HealthPlus Insurance Company. The second is to provide a means of reaching fair solutions to any problems you may have with HealthPlus Insurance Company.

When you have a question, problem or complaint, please call the Customer Service Department at 1-888-212-1512. Customer Service staff will document and date the source of all member contacts. Most inquiries and complaints can be resolved within 2 working days.

If you are not happy with any aspect of HealthPlus Insurance Company's operations or benefits, and you cannot resolve your concerns with the Customer Service Department, you or your authorized representative can use the Member Satisfaction Plan. You must file your grievance within 2 years of the event giving rise to the grievance or within 2 years of discovering the facts giving rise to the grievance.

You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your grievance. You may submit written comments, documents, records and other information relating to the grievance.

Routine Grievance Process

The Member Satisfaction Plan has two internal steps for routine grievances; Grievance and Grievance Appeal. We have 30 calendar days to complete these steps, but we can extend the time by any amount of time that you allow us to. Here's how to use each of the steps:

Step I: Grievance

Whenever your concerns regarding HealthPlus Insurance Company cannot be handled by the Customer Service Department, you can file a grievance. You can initiate this process by contacting HealthPlus Insurance Company

- By phone 1-888-212-1512
- By mail to 2050 South Linden Road, P.O. Box 1700, Flint, Michigan, 48501-1700
- By fax (810) 733-1947
- By personal meeting.

HealthPlus Insurance Company or an outside review entity will respond in writing to your grievance within 15 calendar days of receiving it. At that time, you will be informed of HealthPlus Insurance Company's investigation into your grievance, any action taken and advised of your rights to further review if your grievance has not been resolved in your favor.

Step II: Grievance Appeal

If you are not satisfied with the outcome of your grievance, you may appeal it with a reasonable amount of time following notification of the decision. HealthPlus Insurance Company will schedule a meeting of the Grievance Appeal Committee within 13 calendar days of receipt of your request to file a Grievance Appeal.

You have the opportunity to appear and speak before the Grievance Appeal Committee with or without representation. If you cannot appear in person, you have the option of speaking by telephone or other appropriate technology.

You will receive notification of the Grievance Appeal Committee's decision within 2 calendar days of the meeting. This will be HealthPlus Insurance Company's final decision on your grievance. You will be advised of your right to further appeal to the State of Michigan, Office of Financial and Insurance Services.

External Review

If you have exhausted your rights under the HealthPlus Insurance Company Member Satisfaction Plan, or you have not received a response from us at the end of 15 calendar days from filing their appeal under Step II: Grievance Appeal, you can appeal to the Office of Financial and Insurance Services at no cost to you by writing or calling:

State of Michigan
Office of Financial and Insurance Services
611 Ottawa Street
P. O. Box 30220
Lansing, Michigan 48909-7720

Or call: (517) 373-0220 (Toll Call) 1-877-999-6442 (Toll Free)

By submitting a request for external review, you are authorizing HealthPlus Insurance Company or the outside review entity and your health care providers to disclose health information, including medical records that are relevant to the review process.

If the final decision of HealthPlus Insurance Company was an Adverse Determination, you must file your request for external review with the Office of Financial and Insurance Services within 60 calendar days from receipt of HealthPlus Insurance Company's final decision.

An "adverse determination" is a determination that an admission, availability of care, continued stay or other health care service has been reviewed and denied, reduced or terminated. You need to complete a Request for External Review form from the Office of Financial and Insurance Services to be able to process your request. You can obtain the form from HealthPlus Insurance Company's Customer Service Department.

If your request for external review of an adverse determination is found to be appropriate, the Insurance Commissioner will either review the case or assign the case to an independent review organization with supporting documentation. No later than 7 working days after receipt of the notice from the Office of Financial and Insurance Services, HealthPlus Insurance Company will provide to the independent review organization all information used in making and upholding the Adverse Determination. Upon receipt of a notice from OFIS reversing the Adverse Determination, HealthPlus Insurance Company shall immediately approve the coverage for the member.

Expedited Grievance Process

If you (or another person, including a physician who is authorized in writing to act on your behalf) believes that due to your medical status resolution of your grievance with the normal HealthPlus Insurance Company time frames would seriously jeopardize your life, health or ability to regain maximum function, or would subject you to severe pain that cannot be managed adequately, the expedited grievance process may be utilized. You may only request an expedited grievance when we have denied your request for benefits prior to your having received a service.

HealthPlus Insurance Company or an outside review entity will make a determination whether an Expedited Grievance is warranted based on the particular facts and circumstances surrounding each request. In making such a determination, HealthPlus Insurance Company or the outside review entity must apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. If an Expedited Grievance is not warranted, the Routine Grievance process will be followed.

HealthPlus Insurance Company or an outside review entity shall make and communicate to you (or your authorized representative) and your physician a determination concerning an Expedited Grievance as expeditiously as the medical condition requires, but no later than 72 hours after receipt. This determination may be communicated orally. HealthPlus Insurance Company or an outside review entity shall provide written confirmation of the determination to you (or your Authorized Representative) and your physician within 2 working days or 3 calendar days, whichever is less, following the oral notification.

Expedited External Review

Within 10 calendar days after receiving HealthPlus Insurance Company's (or the outside review entity's) determination on the Expedited Grievance, the member (or his or her authorized representative) may request an expedited external review of the decision through the Office of Financial and Insurance Services.

If the request is accepted for expedited external review, the Office of Financial and Insurance Services will assign the case to an independent review organization and notify both you (or your Authorized Representative) and HealthPlus Insurance Company.

No later than 12 hours after receipt of the notice from Office of Financial and Insurance Services that a case has been accepted for expedited external review, HealthPlus Insurance Company or an outside review entity will provide to the independent review organization in the most expeditious manner all information used in making and/or upholding the Adverse Determination. The Commissioner has 24 hours to make a decision.

Upon receipt of a notice from the Office of Financial and Insurance Services reversing the Adverse Determination, HealthPlus Insurance Company shall immediately approve the coverage for the member.

If you would like more information about your right to an external review, you may contact the Office of Financial and Insurance Services at the address and telephone numbers listed in the first paragraph of the "Routine External Review" section.

Fraud and Abuse

HealthPlus Insurance Company is licensed to do business as an insurance company. Laws regulate the health care services provided by HealthPlus Insurance Company. HealthPlus Insurance Company members, employees and providers must follow these laws.

Fraud can mean lying to get a benefit that is not in your contract. Abuse can mean doing something that leads to extra costs for HealthPlus Insurance Company. It also means paying doctors for services that:

- Are not medically necessary
- Do not meet the standard of care

To report fraud or abuse, call the confidential Compliance Hotline at 1-800-345-9956. You also can write to:

Theresa M. Schurman, Esq.
Compliance Official
2050 S. Linden Rd
Flint, MI 48532

Or go to our Web site at www.healthplus.org. You do not need to give your name.

Examples of fraud and abuse by a member include, but are not limited to, the following:

- Changing a prescription
- Changing medical records
- Falsifying information on a HealthPlus Insurance Company application for benefits
- Letting someone else use your HealthPlus Insurance Company ID card to get medical services

Examples of fraud and abuse by a provider include the following:

- Billing a balance that isn't allowed
- Billing for services that weren't done

- Collusion among providers – providers agreeing on minimum fees they will charge and accept
- Double billing, upcoding and unbundling
- Lying about credentials such as a college degree
- Underutilization – not ordering services that are medically necessary

Examples of fraud and abuse by an employee of HealthPlus Insurance Company include the following:

- Embezzlement or theft
- Excessive salaries and fees to close associates of HealthPlus Insurance Company
- Forging a signature on a contract
- Intentionally submitting false claims
- Lying about a provider's credentials or provider network
- Rigging bids – collusion between state employees and PPO employees
- Self-dealing – awarding a contract based solely on friendship or family relationships

Glossary of Common Health Insurance Terms

**IN THIS SECTION:
Common Health Insurance Terms**

Certificate of Coverage

Certificate of Coverage means the legal description of covered services and other items related to being a member of HealthPlus Insurance Company. The Certificate of Coverage, along with the member's application, HealthPlus Insurance Company PPO Identification (ID) Card, the Group Enrollment and Coverage Agreement, the Schedule of Benefits and rider(s), and any other document issued by Group or HealthPlus Insurance Company fully define the benefits the insured member will receive.

Coinsurance

Coinsurance means the percentage of the fee or cost of a covered service that a member must pay. A member's coinsurance is listed in the Schedule of Benefits.

Copay

Copay (Copayment) means the amount each member must pay per visit to a treating provider for certain covered services. A member's Copays are listed in the Schedule of Benefits and any applicable riders.

Deductible

Deductible means the annual amount a member is required to pay in advance before coverage for health care services begins. A member's deductible is included in the Schedule of Benefits and any applicable rider(s).

Emergency Health Service

Emergency Health Service means medically necessary services rendered by providers for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy, in the case of a pregnant woman; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Excess Charges

Excess Charges means charges for covered services beyond the HealthPlus Insurance Company's allowed amount.

Formulary

Formulary means a list of selected or preferred drug products and supplies available to a member pursuant to relevant HealthPlus Insurance Company organizational policies and procedures.

In-Network Benefit

In-network benefit means any covered services furnished by a preferred provider.

Medically Necessary (Medical Necessity)

Medically Necessary (or Medical Necessity) means services or supplies provided to members that are determined by HealthPlus Insurance Company or its designee to be medically required and appropriate to diagnose or treat a member's physical or mental condition. Also, such services or supplies must:

- Meet widely accepted criteria and professionally recognized standards of health care;
- Not be used primarily for the comfort or convenience of the member, the member's family or caregiver, or the member's treating physician;
- Not be excessive in cost as compared to alternative services or supplies effective for the diagnosis or treatment of the member's physical or mental condition; and
- Not be provided to the member as an inpatient when the services or supplies could be safely and appropriately provided to the member on an outpatient basis.

Non-Preferred Provider

Non-preferred provider means a provider who has not entered into a written agreement with HealthPlus Insurance Company, or otherwise agreed, to provide services to members.

Out-of-Network Benefit

Out-of-network benefit means any covered services furnished by a non-preferred provider

Out of Pocket Costs

Out of pocket costs means all costs that a member must pay based on the Certificate of Coverage as described in the Schedule of Benefits and any applicable riders, including: Copays, coinsurance, deductibles and any Excess Charges.

Out of Pocket Maximum

Out of Pocket Maximum means the total amount of out of pocket costs a member must pay for covered services during each benefit year. Out of pocket costs that do and do not count toward meeting a member's out of pocket maximum are described in the Schedule of Benefits.

Preferred Provider

Preferred provider means a provider who has entered into a written agreement with HealthPlus Insurance Company or otherwise agreed to provide services to HealthPlus Insurance Company PPO members.

Prior Authorization

Prior Authorization means the process of obtaining any necessary prior approval from HealthPlus Insurance Company or its designee. Services that require prior approval are subject to the clinical review criteria of HealthPlus Insurance Company or its designee to ensure quality and efficiency in health care services.

Provider

Provider means a health professional, facility, or agency complying with Public Act 368, Michigan Public Health Code, as amended by Public Act 354 of 1982 or other similar licensing statute of the applicable governing state or governmental unit.

Routine Preventive Services

Preventive Services means those services aimed at prevention, early detection and early treatment of health conditions. This includes routine physical examinations, routine gynecological services, immunizations, preventive diagnostic screenings and well person care. Under the HealthPlus Insurance Company PPO plans the following are considered routine preventive care:

- Childhood immunizations (through age 18)
- Adult immunizations for the flu, Pneumonia and Tetanus/Diphtheria
- Routine adult annual physical
- Routine adult annual gynecological exam
- Well-baby care visits
- Well-child care visits
- Childhood screenings (lead testing, urinalysis and hemoglobin/hemocrit screenings)
- Annual chlamydia screenings as age appropriate
- Annual cervical cancer screenings (Pap smears)
- Breast cancer screenings – annual mammograms as age appropriate
- Osteoporosis screenings as age appropriate
- Colorectal screenings as age appropriate
- Diabetes screenings
- Prostate cancer screenings as age appropriate

Please consult your Certificate of Coverage, Schedule of Benefits and any applicable riders to better understand the coverage for routine preventive care that you and your employer have purchased.

Schedule of Benefits

Schedule of Benefits means the document issued with the Certificate of Coverage containing a brief summary of benefits and the Copay, coinsurance and out of pocket costs (including out of pocket maximum costs) a member is responsible for paying related to covered services. Although a benefit is listed in the Schedule of Benefits, it may require Prior Authorization or may not be a covered service. Benefits are subject to any exclusions and/or limitations contained in the Certificate or in any rider.