

## Schedule of Benefits

### MyPriority HSA<sup>SM</sup>

PPO High Deductible Health Plan (HDHP)  
(HSA Compatible)

### 100% Network — 50% Non-Network

Your Policy provides you with important information about your health care benefits, including prior approval requirements and your Coverage level choices. You may obtain medical services from a Network Provider and receive a higher level of benefits (the Network Benefits level), or you may obtain services from a Non-Network Provider and have coverage under the Non-Network Benefits level.

This Schedule of Benefits provides you with information about your costs at both benefit levels when you receive health care services and the maximum limitations of your health care benefits. Read the entire Policy, Schedule of Benefits and any Plan Addenda carefully.

In accordance with the terms and conditions of the Policy, you are entitled to Covered Services when these services are:

- A. Medically/Clinically Necessary (as defined in the Policy and according to Medical and Behavioral Health policies established by Priority Health with the input of physicians not employed by Priority Health or according to criteria developed by reputable external sources and adopted by Priority Health); and
- B. Not excluded in the Policy or in an Addendum or an Amendment to the Policy.

#### **PRE-EXISTING CONDITION EXCLUSION**

*(This provision does not apply to anyone under the age of 19.)*

Benefits will be excluded for each Illness or Injury or condition not disclosed on your application, for which, during the six month period prior to your effective date, medical advice, diagnosis, care or treatment was recommended by or received from a Health Professional. For purposes of this limitation, "treatment" includes the use of prescription drugs. Genetic information is not treated as a Pre-Existing Condition in the absence of a diagnosis of a condition related to the genetic information.

This Pre-Existing Condition exclusion will apply until the end of the twelve-month period beginning on your effective date under this Policy. The Pre-Existing Condition exclusion does not apply to anyone under the age of 19.

#### **BENEFIT WAITING PERIODS**

Preventive Health Services are excluded from Coverage during Your first 90 consecutive days of Coverage under the Policy, beginning with Your most recent effective date.

Certain surgeries and the treatment of certain conditions are excluded from Coverage during your first 90 consecutive days of Coverage under the Policy, beginning with Your most recent effective date. Surgeries subject to the 90 day waiting period include: Tonsillectomy, Adenoidectomy, Hemorrhoidectomy, Hysterectomy and Bunionectomy, Surgical treatment of the following conditions are also subject to the 90 day waiting period: Cystocele, Enterocele, Rectocele, Urethrocele, Uterine Prolapse, Inguinal Hernia (other than strangulated or incarcerated), Carpal Tunnel Syndrome and Varicose Veins.

#### **PRIOR APPROVAL**

Prior approval is required before you may obtain certain services. If you seek services that require prior approval, without receiving prior approval from us, your benefits will be reduced for those services. You will also be responsible for those services that are beyond those approved, beyond the benefit maximums or excluded from Coverage.

You or your physician must call (800) 269-1260 to obtain prior approval for services. Emergency admissions must be reported to us as soon as reasonably possible after admission.

**DEDUCTIBLE AND OUT-OF-POCKET MAXIMUMS**

**A. Deductibles:**

The Deductible is the amount you must pay for Covered Services during the Contract Year before benefits will be paid. Your Deductible will also take into account any monies paid under your prescription drug benefits.

The Network Benefits Deductible is applicable to all Covered Services except certain preventive health services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness or disability.

Priority Health’s preventive health care guidelines were developed and approved by Priority Health network physicians. These guidelines are available on our Web site at *priority-health.com* or you may request a copy from our Customer Service Department.

Prenatal and pregnancy services are not Covered under the Policy.

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

The Deductibles renew each Contract Year. Deductible amounts do not carry over into a new Contract Year.

Individual Contract and Family Contract Deductibles:

- If you are the only individual on your contract, you have a Subscriber Only Contract and the Subscriber Only Contract Deductible applies.
- If you have more than one individual on your contract, you have a Subscriber Plus Dependent(s) Contract and only the Subscriber Plus Dependent(s) Deductible applies. The Subscriber Plus Dependent(s) Contract Deductible can be satisfied by any one family member or by any combination of family members.

**Notwithstanding the above, the following out-of-pocket Member costs do not apply towards the Deductibles:**

- any monies you paid for Non-Covered Services; and
- any monies you paid for Covered Services that exceed the annual day, visit or dollar benefit maximum for a specific benefit and therefore, denied as non-Covered Services; and
- any reduction in payment for failure to preauthorize services; and
- any monies you paid to providers for Non-Network Benefits that exceed Reasonable and Customary; and
- any monies you paid for Covered Services after the Lifetime Benefit Maximum is exhausted.

The Network and Non-Network Deductibles are calculated separately. Deductible amounts you pay, whether under the Network Benefits or Non-Network Benefits, are excluded from any Network or Non-Network Out-of-Pocket Maximums.

<b>Deductibles</b>	<b>Network Benefits</b>	<b>Non-Network Benefits</b>
Subscriber Only Contract	\$2,000.00	\$4,000.00
Subscriber Plus Dependent(s) Contract	\$4,000.00	\$8,000.00

**B. Non-Network Benefits Out-of-Pocket Maximums:**

The Non-Network Benefits Out-of-Pocket Maximum limits the total amount that you will pay toward Covered Services under the Non-Network Benefits level during a Contract Year. Once the applicable Out-of-Pocket Maximum for the Non-Network Benefits level is met, all further Covered Services for that Contract Year for Non-Network Benefits will be paid at 100% of the lesser of billed charges or Reasonable and Customary Charges.

If you have an Individual Contract, when calculating your Non-Network Out-of-Pocket Maximum, we will include all Copayments and Deductibles you paid toward Covered Services under the Non-Network Benefits level during a Contract Year. If you have a Family Contract, we will include all Copayments and Deductibles you and your family paid collectively toward Covered Services under the Non-Network Benefits level during a Contract Year.

Out-of-Pocket Maximums	Network Benefits	Non-Network Benefits
Subscriber Only Contract	Not Applicable	\$ 9,000.00
Subscriber Plus Dependent(s) Contract	Not Applicable	\$18,000.00

Amounts paid for any of the following will not apply toward the Non-Network Benefits Out-of-Pocket Maximum:

- any reduction in benefits for failure to obtain prior approval when necessary
- any monies you paid for non-Covered Services
- any monies you paid for Covered Services that exceed the annual day/visit or dollar benefit maximum for a specific benefit and therefore, denied as non-Covered Services
- any monies you paid to providers for Non-Network Benefits that exceed Reasonable and Customary
- any monies you paid for Covered Services after the Lifetime Benefit Maximum is exhausted

If the Non-Network Benefits Subscriber Only Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Covered Non-Network Benefits Services that apply toward Non-Network Benefits Out-of-Pocket Maximums as incurred by that person for the rest of the Contract Year. If the Non-Network Benefits Subscriber Plus Dependent(s) Out-of-Pocket Maximum is reached during a Contract Year, Priority Health will pay 100% of the Reasonable and Customary Charges for Covered Non-Network Benefits Services incurred by you and all your Covered Dependents for the rest of the Contract Year.

Note: If the reduction in benefits for failure to obtain prior approval applies, the amount Priority Health pays will be reduced even if the Non-Network Benefits Out-of-Pocket Maximum has been reached.

## Covered Benefits

Benefits	Network Benefits	Non-Network Benefits
<p><b>Preventive Health Services</b> Per our Preventive Health Care Guidelines</p> <p>Pre-natal and pregnancy services are not Covered under the Policy.</p> <p><b>Note:</b> Coverage for Preventive Health Care Services is subject to a 90-day waiting period.</p>	<p>After a 90-day waiting period which begins on your effective date:</p> <ul style="list-style-type: none"> <li>• 100% Coverage for Preventive Health Care Services described in our Preventive Health Care Guidelines</li> <li>• Deductible waived</li> </ul>	<p><b>Not Covered</b></p>
<b>PHYSICIAN SERVICES</b>		
<p><b>Office Visits and Urgent Care Visits</b> Visits for Sickness, Injury, or follow-up (face-to-face, telephonic, or through secure electronic portal)</p>	<p>100% Coverage. Deductible applies.</p>	<p>50% Coverage of Reasonable and Customary Charges. Deductible applies.</p>
<p><b>Inpatient Hospital Visits</b></p>	<p>100% Coverage. Deductible applies.</p>	<p>50% Coverage of Reasonable and Customary Charges. Deductible applies.</p>
<p><b>Surgery</b></p>	<p>100% Coverage. Deductible applies.</p>	<p>50% Coverage of Reasonable and Customary Charges. Deductible applies.</p>
<p><b>Ambulatory Surgery Center Services</b></p>	<p>100% Coverage. Deductible applies.</p>	<p>50% Coverage of Reasonable and Customary Charges. Deductible applies.</p>

Benefits	Network Benefits	Non-Network Benefits
<b>Allergy Testing and Serum</b>	100% Coverage. Deductible applies.	50% Coverage of Reasonable and Customary Charges. Deductible applies.
<b>Allergy Injections</b>	100% Coverage. Deductible applies.	50% Coverage of Reasonable and Customary Charges. Deductible applies.
<b>Maternity Services</b> (Prenatal delivery and postnatal)  <b>Note:</b> Complications of a Pregnancy, as defined in Section 16 of the Policy, are Covered subject to the terms and conditions of the Policy.	<b>Not Covered</b> (including Physicians' fees and any other related charges)	<b>Not Covered</b> (including Physicians' fees and any other related charges)
<b>Family Planning</b>	<b>Not Covered</b> (including Physicians' fees and any other related charges)	<b>Not Covered</b> (including Physicians' fees and any other related charges)
<b>Infertility Services</b>	<b>Not Covered</b> (including Physicians' fees and any other related charges)	<b>Not Covered</b> (including Physicians' fees and any other related charges)
<b>Tubal Ligation</b>	<b>Not Covered</b> (including Physicians' fees and any other related charges)	<b>Not Covered</b> (including Physicians' fees and any other related charges)
<b>Vasectomy</b>	<b>Not Covered</b> (including Physicians' fees and any other related charges)	<b>Not Covered</b> (including Physicians' fees and any other related charges)
<b>Temporomandibular Joint Dysfunction or Syndrome</b>	<b>Not Covered</b> (including Physicians' fees and any other related charges)	<b>Not Covered</b> (including Physicians' fees and any other related charges)
<b>Orthognathic Surgery</b>	<b>Not Covered</b> (including Physicians' fees and any other related charges)	<b>Not Covered</b> (including Physicians' fees and any other related charges)

Benefits	Network Benefits	Non-Network Benefits
<p><b>Certain Surgeries and Treatments</b></p> <ul style="list-style-type: none"> <li>• Reconstructive surgeries <ul style="list-style-type: none"> <li>○ Blepharoplasty</li> <li>○ Breast reduction</li> <li>○ Panniculectomy</li> <li>○ Rhinoplasty</li> <li>○ Septorhinoplasty</li> <li>○ Surgical treatment of male gynecomastia</li> </ul> </li> <li>• Skin disorder treatments <ul style="list-style-type: none"> <li>○ Scar revision</li> <li>○ Keloid scar treatment</li> <li>○ Treatment of hyperhidrosis</li> <li>○ Excision of lipomas</li> <li>○ Excision of seborrheic keratoses</li> <li>○ Excision of skin tags</li> <li>○ Treatment of vitiligo</li> <li>○ Port wine stain and hemangioma treatment</li> </ul> </li> <li>• Sleep apnea treatment procedures</li> </ul>	<p><b>Not Covered</b> (including Physicians' fees and any other related charges)</p>	<p><b>Not Covered</b> (including Physicians' fees and any other related charges)</p>
<p><b>Treatment of Morbid Obesity</b></p> <ul style="list-style-type: none"> <li>• Weight loss programs</li> <li>• Bariatric surgery</li> </ul>	<p><b>Not Covered</b> (including Physicians' fees and any other related charges)</p>	<p><b>Not Covered</b> (including Physicians' fees and any other related charges)</p>
<p><b>Transplants</b></p>	<p>100% Coverage. Deductible applies.</p>	<p><b>Not Covered</b> (including Physicians' fees and any other related charges)</p>

Benefits	Network Benefits	Non-Network Benefits
<b>HOSPITAL SERVICES</b>		
(Including radiology examinations and laboratory services)		
<p><b>Inpatient Hospital and Inpatient Longterm Acute Care Services</b> (Including observation care, transplants and maternity stays for a mother and her Newborn of up to 96 hours following a Medically/Clinically Necessary cesarean section)</p> <p>Prenatal and pregnancy services are not Covered under this Policy.</p>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Prior approval required at least five working days in advance, except in emergencies or for hospital stays for a mother and her Newborn of up to 96 hours following a Medically/Clinically Necessary cesarean section. Failure to obtain prior approval will result in a \$250.00 reduction in benefits.</li> <li>• Notification required for admissions following emergency room care</li> <li>• Deductible applies</li> </ul>	<ul style="list-style-type: none"> <li>• 60% Coverage of Reasonable and Customary Charges</li> <li>• Prior approval required at least five working days in advance, except in emergencies or for hospital stays for a mother and her Newborn of up to 96 hours following a cesarean section. Failure to obtain prior approval will result in a \$250.00 reduction in benefits.</li> <li>• Notification required for admissions following emergency room care</li> <li>• Deductible applies</li> </ul>
<p><b>Outpatient Hospital Services</b> (Including ambulatory surgery center facility charges)</p>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Some services may require prior approval, including certain radiology examinations</li> <li>• Deductible applies</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges</li> <li>• Some services may require prior approval, including certain radiology examinations</li> <li>• Deductible applies</li> </ul>
<b>MEDICAL EMERGENCY SERVICES</b>		
<p><b>Emergency Room Services</b> (Non-emergency use of the emergency room is not Covered)</p>	<p>100% Coverage. Deductible applies.</p>	<p>Emergency room services with Network and Non-Network Providers are paid at the Network level of benefits</p>
<p><b>Urgent Care Facility Services</b></p>	<p>See <b>Office Visits and Urgent Care Visits</b> category under PHYSICIAN SERVICES section of this Schedule of Benefits</p>	<p>See <b>Office Visits and Urgent Care Visits</b> category under PHYSICIAN SERVICES section of this Schedule of Benefits</p>
<p><b>Ambulance Services</b> (air or ground)</p>	<p>100% Coverage. Deductible applies</p>	<p>Network and Non-Network ambulance services are paid at the Network level of benefits.</p>

Benefits	Network Benefits	Non-Network Benefits
<b>BEHAVIORAL HEALTH SERVICES</b>		
<b>Mental Health Inpatient</b> (including partial hospitalization)	<b>Not Covered</b> (including Physicians' fees and any other related charges)	<b>Not Covered</b> (including Physicians' fees and any other related charges)
<b>Mental Health Outpatient</b>	<b>Not Covered</b> (including Physicians' fees and any other related charges)	<b>Not Covered</b> (including Physicians' fees and any other related charges)
<b>Substance Abuse Care</b> (Inpatient and Outpatient)	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Prior approval required for Inpatient services. Failure to obtain prior approval will result in a \$250.00 reduction in benefits.</li> <li>• Deductible applies</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges</li> <li>• Prior approval required for Inpatient services. Failure to obtain prior approval will result in a \$250.00 reduction in benefits.</li> <li>• Deductible applies</li> </ul>
<b>REHABILITATIVE MEDICINE SERVICES</b>		
<b>Rehabilitative Medicine Services</b> Outpatient Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation, Osteopathic Manipulations and Chiropractic Spinal Manipulations	<ul style="list-style-type: none"> <li>• 100% Coverage up to a combined benefit maximum of 30 visits per Contract Year*</li> <li>• Deductible applies.</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges up to a combined benefit maximum of 30 visits per Contract Year*.</li> <li>• Deductible applies</li> </ul>

Benefits	Network Benefits	Non-Network Benefits
<b>OTHER SERVICES</b>		
<b>Radiology Examinations and Laboratory Procedures</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• High-tech imaging services require prior approval. Failure to obtain prior approval will result in a \$250.00 reduction in benefits.</li> <li>• Deductible applies</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges</li> <li>• High-tech imaging services require prior approval. Failure to obtain prior approval will result in a \$250.00 reduction in benefits.</li> <li>• Deductible applies</li> </ul>
<b>Durable Medical Equipment</b> (rent, purchase or repair); <b>and Prosthetic and Orthotic/Support Devices</b>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Prior approval required for devices over \$1,000.00</li> <li>• Deductible applies</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges up to a benefit maximum of \$2,000.00 per Member per Contract Year</li> <li>• Prior approval required for devices over \$1,000.00</li> <li>• Deductible applies</li> </ul>
<b>Non-Acute Hospital Facility Services</b> <ul style="list-style-type: none"> <li>• Skilled Nursing Facility</li> <li>• Subacute Facility</li> <li>• Inpatient Rehabilitation Facility</li> <li>• Hospice Facility</li> </ul>	<ul style="list-style-type: none"> <li>• 100% Coverage up to the benefit maximum of 60 days per Contract Year*</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250.00 reduction in benefits.</li> <li>• Deductible applies</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges up to the benefit maximum of 60 days per Contract Year*</li> <li>• Prior approval required. Failure to obtain prior approval will result in a \$250.00 reduction in benefits.</li> <li>• Deductible applies</li> </ul>
<b>Home Health Care</b> (Including hospice care in the home, excluding Rehabilitative Medicine)  <b>Note:</b> Rehabilitative services provided in the home are subject to the limitations of the Rehabilitative Medicine Services benefits described above.	<ul style="list-style-type: none"> <li>• 100% Coverage up to the benefit maximum of 60 days per Contract Year*</li> <li>• Prior approval required except for hospice services in the home. Failure to obtain prior approval will result in a \$250.00 reduction in benefits.</li> <li>• Deductible applies</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges up to the benefit maximum of 60 days per Contract Year*</li> <li>• Prior approval required except for hospice services in the home. Failure to obtain prior approval will result in a \$250.00 reduction in benefits.</li> <li>• Deductible applies</li> </ul>
<b>Dietician Services</b>	<ul style="list-style-type: none"> <li>• 100% Coverage to a maximum benefit of 6 visits per Member per Contract Year*</li> <li>• Deductible applies</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage of Reasonable and Customary Charges up to a maximum benefit of 6 visits per Member per Contract Year*</li> <li>• Deductible applies</li> </ul>

## MEDICAL PLAN PHARMACY SERVICES

In general, Covered drugs are treated as medical benefits when administered in an inpatient or emergency setting, or when the drug requires injection or infusion by a Health Professional. Exceptions to this rule are outlined in our medical policies.

The Deductible will apply to Covered medical plan pharmacy services that are detailed below.

Medication Formulary - A list of both Generic and Brand Name Drugs, including Specialty Drugs, approved by Priority Health Pharmacy and Therapeutics Committee for use by our Members. Preferred Brand Name Drugs are usually Brand Name Drugs that have been on the market for a while or are commonly prescribed and have been selected based on their clinical effectiveness and safety. Non-preferred Brand Name Drugs are usually the highest cost drugs in a given category that have lower-cost alternatives with equal or better clinical effectiveness.

Specialty Drug - Drugs listed on the Medication Formulary meeting certain criteria, such as:

- drugs or drug classes whose cost on a per- month or per-dose basis exceeds the threshold established by the Centers for Medicare and Medicaid Services; or
- drugs that require special handling or administration; or
- drugs that have limited distribution; or
- drugs in selected therapeutic categories.

Specialty Pharmacy - A Pharmacy that specializes in the handling, distribution, and patient management of Specialty Drugs.

Benefits	Network Benefits	Non-Network Benefits
<p><b>Drugs Requiring Administration by a Health Professional</b> (injectable and infusible drugs requiring administration by a Health Professional in a medical office, home or outpatient facility)</p>	<ul style="list-style-type: none"> <li>• 100% Coverage</li> <li>• Deductible applies</li> <li>• Prior approval required. Step therapy may be required before drugs will be Covered.</li> <li>• Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy.</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Coverage to a maximum benefit of \$25,000.00 per Member per Contract Year</li> <li>• Deductible applies</li> <li>• Amounts paid after Deductible do apply toward Out-of-Pocket Maximums</li> <li>• Prior approval required. Step therapy may be required before drugs will be Covered.</li> <li>• Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy.</li> </ul>

**PRESCRIPTION DRUG BENEFITS - RETAIL PHARMACY**

<b>Benefits</b>	<b>Network Benefits</b>	<b>Non-Network Benefits</b>
<p><b>Retail Pharmacy Services</b> (prescription drugs obtained at a retail Network Pharmacy dispensed in a 31-day supply per prescription or refill or through our mail order service dispensed in a 90-day supply per prescription or refill)</p> <p>In general, Covered retail pharmacy drugs are treated as outpatient prescription drug benefits when they can be self-administered regardless of the setting. Exceptions to this rule are outlined in our medical policies.</p> <p><b>Note:</b> If you elect to receive a Brand Name Drug when the prescription allows a Generic Drug substitution, you may be responsible for difference in cost between the Generic Drug and the Brand Name Drug.</p> <p>Prior approval or step therapy may be required.</p>	<ul style="list-style-type: none"> <li>• 100% Coverage for a Generic or Brand Name Drug on our Medication Formulary. Limitations and exclusions apply.</li> <li>• Deductible applies</li> <li>• Self-administered injectable drugs must be obtained at a Network Pharmacy (including Participating Specialty Pharmacies for selected drug categories)</li> <li>• Priority Health may require selected Specialty Drugs be obtained by your provider through a Specialty Pharmacy</li> </ul>	<p><b>Not Covered.</b></p> <p><b>Exception:</b> Prescription drugs dispensed by a Non-Network Pharmacy during a Medical Emergency or Urgent Care situation will be Covered under the Retail Pharmacy Services Network Benefits level.</p>

**MAXIMUM LIMITATIONS**

\* **Benefit Maximums:** Benefit maximums up to a certain number of days/visits per Contract Year are reached by combining either Network or Non-Network Benefits up to the limit for one or the other, but not both. (Example: If Network Benefits is for 60 visits and Non-Network Benefits is for 60 visits, the maximum benefit is 60 visits, not 120.) Benefit maximums apply even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

Created: 2010

Doc\_2126