My**Priority** HSA℠

PPO Insurance Policy

Preferred Provider Organization Plan

High Deductible Health Plan (HDHP)

HSA Compatible

Priority Health Insurance Company,

A subsidiary of Priority Health

CANCELLATION PROVISIONS

Cancellation during first 10 days. During a period of 10 days after the date the policyholder receives the policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to such notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

Cancellation after 10 days. A policyholder may cancel the policy after the first 10 days following receipt of the policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, the insurer shall promptly refund to the policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

Cancellation during the first 30 days. During a period of 30 days after the date the policyholder receives the policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to such notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

Cancellation after 30 days. A policyholder may cancel the policy after the first 30 days following receipt of the policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, the insurer shall promptly refund to the policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

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INDIVIDUAL INSURANCE POLICY –

PRIORITY HEALTH INSURANCE COMPANY – PREFERRED PROVIDER ORGANIZATION PLAN

Policy Delivered in Michigan – 2010

SECTION 1. About This Policy

This Policy has been applied for as Individual Coverage. Read this entire Policy carefully. It sets the terms and conditions of Coverage and describes the health care services that are Covered for Members. This contract describes the rights and obligations of Members and Priority Health. It is your responsibility to understand the terms and conditions of your health benefits contained in this Policy.

This Policy only Covers Non-Occupational Injuries and Non-Occupational Illnesses, and it only Covers Medically/Clinically Necessary services or supplies that are furnished while a person is a Member. In some circumstances certain medical services are not Covered or may require prior approval by Priority Health.

Health Services that might otherwise be Covered may be limited or not Covered due to a Pre-Existing Condition. See Section 6 of this Policy.

NOTE: You are responsible for those Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary listed in the Schedule of Benefits.

Coverage under this Policy is available to the Subscriber and the Subscriber's Covered Dependents (Members), as defined in this Policy. For Coverage to become effective, the Subscriber, on behalf of himself or herself and his or her Covered Dependents, must submit to us a completed application form and, and upon approval, the required Premium.

Newborns born after the effective date of this Policy must be enrolled and any additional Premium paid within 31 days from birth if Coverage is to continue beyond the 31-day period.

RIGHT OF CONTRACT EXAMINATION

The Subscriber may return this Policy to us within 10 days after the date of delivery if he or she is not satisfied. If the Subscriber returns this Policy, it will be void from its effective date and any Premium paid will be returned. This provision or the fact of its existence will not be used to defeat or reduce any other right of the Subscriber.

IMPORTANT NOTICE. YOUR POLICY MAY NOT APPLY! PLEASE READ!

This Policy was issued based on the information in your application form, which has become part of this Policy. If, to the best of your knowledge and belief, there is any misstatement in your application form, you must let us know immediately about the incorrect or omitted information; otherwise, your Policy may not be valid.

If any information on your application form is incorrect or incomplete, please write to us at 1231 East Beltline, NE, P.O. Box 269, Grand Rapids, MI 49501, within 10 days of receiving the Policy.

Words that are capitalized in this Policy are special terms that are defined in Section 16. The terms "we," "us" and "our" refer to Priority Health. The terms "you," "your" and "yourself" refer to the Member, whether enrolled with Priority Health as a Subscriber or Covered Dependent.

If you have any questions about Coverage, contact our Customer Service Department at:

Priority Health
Customer Service Department, MS FH 5
34505 West Twelve Mile Road
Farmington Hills, MI 48331
800 528-8762
or
on our website at *priorityhealth.com*

SECTION 2. Eligibility

Any person and his or her dependents who are listed on the application and who have met the eligibility requirements stated in this Section and this Policy will be eligible for enrollment as Members.

A. Subscriber

You may enroll as a Subscriber if you:

(1) are a current resident of Michigan and have resided in the United States for six consecutive months prior to your enrollment application submission date; and

(2) are not eligible for any group health coverage (excluding COBRA) and are not enrolled in any group or association health coverage; and

(3) do not intend to travel within the first six months of Coverage to a destination where war, hostilities or insurrection exist or are imminent; and

(4) are not excluded because you are eligible for or enrolled in other health coverage as noted below (eligibility for Medicaid or VA benefits does not exclude you from coverage under a MyPriority individual health plan); and

(5) are an adult between the ages of 18 and 64 ½; and

(6) submit a completed and signed application form and, upon approval, the required premium; and

(7) meet the medical criteria set forth in the application form and are approved for enrollment.

You are *not* eligible to enroll in MyPriority individual Coverage if you:

(1) are enrolled in any other individual health coverage; or

(2) are eligible for and enrolled in any group health coverage (excluding COBRA); or

(3) are eligible for or enrolled in any governmental health insurance programs, including Medicare, Children's Special Heath Care Services, CHIP (such as MIChild of Michigan), and prescription drug coverage; or

(4) are eligible for any public or private financial assistance programs related to health coverage, including, but not limited to, prescription drug coverage; or

(5) are in detention or incarcerated in a facility such as a youth home, jail or prison, are in the custody of law enforcement officers, or are on release for the sole purpose of receiving medical treatment.

B. Covered Dependents.

You may enroll as a Covered Dependent if you:

(1) meet the medical criteria set forth in the application form and are approved for enrollment; and

(2) do not intend to travel within the first six months of Coverage to a destination where war, hostilities or insurrection exist or are imminent; and

(3) are legally married to the Subscriber, a resident of Michigan, and not older than 64 ½ years old; or

(4) are the Subscriber's child (including a stepchild, legally adopted child or natural child) and you are:

(a) between the ages of 15 days and 26 years; or

(b) are unmarried and incapacitated and over the maximum child age described in (a) above. Read subsection C. below to find out about available Coverage.

Eligibility under section (4)(a) above continues to the day the Subscriber's child turns age 26.

You are *not* eligible to enroll as a Covered Dependent if you:

(1) are enrolled in any other individual health coverage; or

(2) are eligible for and enrolled in any group health coverage (excluding COBRA); or

(3) are eligible for or enrolled in any governmental health insurance programs, including Medicare, Children's Special Heath Care Services, CHIP (such as MIChild of Michigan), and prescription drug coverage; or

(4) are eligible for any public or private financial assistance programs related to health coverage, including, but not limited to, prescription drug coverage.

(5) are in detention or incarcerated in a facility such as a youth home, jail or prison, are in the custody of law enforcement officers, or are on release for the sole purpose of receiving medical treatment.

Special rules apply to a newborn. A newborn child is eligible under the following conditions:

(1) born after the effective date of this Policy, and

(2) born to the Subscriber or the Subscriber's spouse

or

the mother of the child is a Covered Dependent on this Policy under the age of 18;

C. Continuation of Coverage for Unmarried and Incapacitated Dependents.

We will continue to provide Coverage for the Subscriber's and the Subscriber's spouse's unmarried and incapacitated dependent past the maximum age for dependent children. A dependent is incapacitated if all of the following apply:

(1) The dependent is the child of the Subscriber or the Subscriber's spouse;

(2) The dependent is not capable of self-sustaining employment and is unable to independently socialize without assistance because of a mental or physical disability that is incapacitating. Certain diagnosis, including but not limited to attention deficit disorder or depression, by themselves, are not evidence of incapacity. Learning disabilities or the inability to "hold a job" in the absence of mental retardation are not evidence of incapacity. Examples of diagnoses that may constitute an incapacitating condition include Down Syndrome and traumatic brain injury.

(3) The incapacity must have started before age 26; and

(4) The dependent relies on the Subscriber for more than half of his or her support, as determined under Section 152 of the Internal Revenue Code, as amended.

We must receive proof from you that the dependent is incapacitated within 31 days after the dependent reaches the maximum age for dependent children if the child is already Covered or within 31 days of initial enrollment. After that, you must give us proof when we ask for it, from time to time, but not more often than once each year.

Coverage for an incapacitated dependent will not be continued after any of the following happens:

(1) The dependent is no longer a dependent of the Subscriber or the Subscriber's spouse as described in subsection (4) above;

(2) The dependent's incapacity ends;

(3) We do not receive proof that the dependent is incapacitated within 31 days of requesting such information; or

(4) The dependent's Coverage as a dependent ends for any reason other than reaching the maximum age for dependent children (such as marriage).

SECTION 3. Enrollment

This section describes what you need to do to enroll or to enroll your eligible dependents. If your Coverage has been terminated for cause, you may not re-enroll even if you do these things. Read Section 9 to learn more about termination for cause.

To enroll as a Subscriber, you must fill out an application form, sign it, and return it to us with authorization for electronic funds transfer for Premium payments. On the application form, you must list every person being enrolled, and give the information asked for about each person.

In addition, eligible dependents may be enrolled as described below.

A. Enrollment of Dependents.

(1) As Subscriber, you may apply for Coverage for Dependents meeting the eligibility requirements in Section 2. If we approve the application change form Coverage will become effective as described in Section 4. As Subscriber, you must complete and

submit an application change form to us and pay any additional required Premium payment. We have the right to decline the application for any Dependent over age 18.

(2) We will Cover routine inpatient care for an eligible Newborn child from the date of birth to the date the child or the mother is discharged, whichever comes first, if the mother is a Covered Spouse or Covered Child under age 18. If you want Coverage to continue after discharge, you must fill out and return to us an application change form within 31 days after the child is born.

(3) We will Cover an eligible Newborn child for Injury or Illness (including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities) for the first 31 days from birth. If you want the newborn's Coverage to continue beyond the first 31-day period, you must fill out and return to us an application change form within 31 days after the child is born and pay any additional required Premium payment.

(4) A legally adopted child may be enrolled as a Covered Dependent if the child meets the eligibility requirements described in Section 2.B if you complete and submit to us a signed application change form, with any additional required Premium payment, within 31 days from the date of the child's placement in your physical custody.

B. Special Enrollment as a Result of a Court or Administrative Order.

If you provide us with a copy of a court judgment, decree or order (including approval of a settlement agreement) that provides for benefit coverage with respect to a child of a Subscriber, and is made pursuant to a State domestic relations law, you may enroll the child. The child must be otherwise eligible for Coverage as a Covered Dependent under Section 2.B except that the child is not required to be dependent on you for more than half of his or her support.

As Subscriber, you must complete and submit a change form to us along with any additional required Premium payment. Coverage will become effective upon our acceptance of the court or administrative order, the change form and any required Premium payment.

This special enrollment option is not subject to the Qualified Medical Child Support Order (QMCSO) requirements due to the fact that this is not a group health plan.

C. Notification of Change in Status or Other Changes that Affect Coverage and Eligibility

You must let us know about any changes that affect Coverage under this Policy. You do that by filling out a change form and returning it to us or by calling our Customer Service Department. You must notify us if any of the following happens to anyone Covered under this Policy:

(1) change of address;

(2) change in Covered Dependent status;

(3) eligibility for group health coverage (excluding COBRA);

(4) eligibility for federal, state, county or local governmental or quasi-governmental health coverage;

(5) eligibility for public or private financial assistance programs related to health coverage, including but not limited to prescription drug coverage; or

(6) coverage by any other individual, group or association health plan.

These are just examples, and you must let us know about any other change that, according to this Policy, affects your Coverage or Coverage for your Covered Dependents.

You must let us know about the change within 31 days after the change happens. If you do not, and we discover the change, we will use the correct information to determine whether or not services you receive are Covered.

D. Loss of Eligibility.

You will lose your eligibility and your Coverage will terminate if you no longer meet the eligibility criteria listed in Section 2 of this Policy, or if you lose your eligibility as described in Section 9.B.

E. Genetic Testing

Enrollment under this Section 3 is not contingent on undergoing genetic testing or disclosing results of any genetic testing to us.

SECTION 4. Effective Dates of Coverage

Your Coverage under this Policy will become effective on the latest of:

(1) The effective date you request on your application; or

(2) The effective date we provide in our approval letter.

Coverage for newly eligible Dependents under this Policy (as described in Section 2.B.) will become effective on the latest of:

(1) The effective date your request on your application; or

(2) The underwriting approval date.

SECTION 5. Obtaining Covered Services

I. How The Plan Works.

This plan is designed as a Preferred Provider Organization ("PPO") health plan for your medical benefits. The plan provides a network of medical care providers ("Network Providers") who have agreed to provide services for specified fees. Under the plan, you may choose to use either Network services or Non-Network services (as described in this section), at the point in time when Covered Services or Supplies are desired. In order to receive Network services, you are responsible to ensure that the Provider participates in the Network at the time of service.

As a Member you may obtain medical services directly from a Network Provider, allowing you to receive "Network Benefits". You will be responsible for the Copayments, Deductibles, Coinsurance and any amounts over Reasonable and Customary shown under the heading of "Network Benefits" in the Schedule of Benefits. Generally, Network Benefits will cost you less out-of-pocket than Non-Network benefits. If you receive services from a Non-Network Provider you will receive "Non-Network Benefits" (except as otherwise specified in this Policy). You will be responsible for the Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary shown under the heading of "Non-Network Benefits" in the Schedule of Benefits. At any time during your course of treatment, you have the option to return to a Network Provider for medical care. If you do, the plan will cover care by a Network Provider at the Network Benefit level.

To verify the current network status of Network Providers, contact our Customer Service Department at 800 528-8762 or on our website at *priorityhealth.com.* You are responsible for determining whether a provider is part of the Network before receiving services. Unless otherwise specified in this Policy, benefits will be paid based on the network status of the provider as of the day services are received.

Generally, you will have the lowest out-of-pocket amounts and the most cost savings with the Network Benefit option. The Non-Network Benefit option typically involves a higher out-of-pocket expense. But the Non-Network Benefits option allows you to choose any provider, anywhere, and at any time.

Non-Network Benefits are available on a world-wide basis. Prior approval of certain services is required as described in Section 5.II. Benefits may be reduced for failure to obtain or follow prior approval requirements.

A. Network Providers.

Network Providers can provide your medical care, including your Preventive Health Services, Primary Care and Specialty Care. A Network Provider can provide or coordinate services such as lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Only those services provided by a Network Provider will be covered as Network Benefits, except as otherwise stated in this Policy.

B. Termination of Provider's Participation.

A Network Provider, or the Network, can terminate the provider's contract and you will need to change to a different Network Provider to maintain Network Benefits. We do not promise that you will be able to receive services from a specific Network Provider the whole time you are covered by this Policy.

If, at the time a Network Provider's contract with us is terminated, you are receiving on-going care with the provider and the provider is able to continue treating you, you may continue to be treated by this provider for up to 90 days or until the Network has made arrangements for another provider to provide the services. In addition, if, at the time a Network Provider's contract with us is terminated, you are undergoing treatment for a terminal illness, you may continue to be treated by that provider for the remainder of your life. This paragraph does not apply if the Network Provider's contract has been terminated for quality of care reasons.

We will assist you in finding another Network Provider and in receiving care during the transition if your Network Provider's contract is terminated. If you have any questions, please call our Customer Service Department at 800 528-8762.

C. Referral Care and Second Medical Opinion.

Your physician, or another health professional, may refer you to a provider who does not participate in the Network. You are responsible to make sure each provider participates with the Network before receiving services in order to receive the Network Benefit level.

A second medical opinion from a specialist may be appropriate for certain health conditions and proposed surgeries. We will Cover second medical opinions from Physicians having skills and training substantially similar to those of the Physician making the original treatment recommendation. Benefits for second opinion services will be based on the Network status of the provider at the time of service. Any tests, procedures, treatments or surgeries recommended by the consulting provider must be performed by a Network Provider to receive benefits at the Network Benefits level.

Note: Sometimes a provider might refer you for, or suggest, a service that the plan does not Cover. The plan will not cover a service that would not be Covered otherwise just because a provider referred you or suggested the service.

D. Review of Health Care Services and Supplies.

Priority Health can review services and supplies that health professionals recommend or provide to decide whether those services and supplies are Covered under this plan. If Priority Health decides that the services and supplies are not Covered, Priority Health will let you know. If you disagree with the decision and want that decision to be reviewed, you must follow the procedures described in Section 10 of this Policy.

E. Additional Information

We will provide you with the following additional information when you request it by calling or writing our Customer Service Department:

(1) You may request a current Provider Directory. This lists our current provider network.

(2) Any prior approval requirements and any limitations, restrictions or exclusions on services, benefits or providers.

(3) The type of financial relationships between the Network and its providers.

(4) How we evaluate new technology for inclusion as a Covered Service.

(5) How we evaluate new drugs for inclusion in our formulary.

(6) A printed version of this Policy.

You may request this information by calling or writing to our Customer Service Department at the phone number or address below.

Priority Health
Customer Service Department, MS FH 5
34505 West Twelve Mile Road
Farmington Hills, MI 48331
800 528-8762
or
on our website at *priorityhealth.com*

F. Items or Services Received from or Ordered by any Provider Included on the Office of Inspector General's List of Excluded Individuals/Entities.

Consistent with the federal guidelines for payment of sanctioned providers, Priority Health will not pay claims for items or services furnished, ordered, or prescribed by any provider listed on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities. The basis for exclusion may include convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans.

You will be responsible for the full payment of items or services furnished, ordered, or prescribed by any provider included on the OIG List of Excluded Individuals/Entities. This includes items or services such as prescriptions written by or medical equipment ordered by a provider included on this list. This list is available on the OIG website at www.hhs.gov/oig.

II. Prior Approval Of Benefits.

Certain services and supplies that Health Professionals recommend or provide to you must receive prior approval from Priority Health before they can be Covered.

General Services categories for which prior approval from Priority Health is required:

(1) All inpatient services (including inpatient hospice services and inpatient substance abuse services).

(2) Durable medical equipment over $1,000.00 and all rentals.

(3) Prosthetics and orthotics over $1,000.00, all rentals and all shoe inserts.

(4) Certain high-tech radiology examinations, including positron-emission tomography (PET) scans, magnetic resonance imaging (MRI), computed tomography (CT scans) and nuclear cardiology studies.

(5) Selected injectable drugs in certain categories.

(6) Home health care, including home infusion services. Hospice services in the home do not require prior approval.

(7) Transplants and evaluations for transplants.

8) Reconstructive surgery.

The list of services that require prior approval from Priority Health may be updated from time to time as new technology and standards of care emerge. A current detailed list is available by calling our Customer Service Department at 800 528-8762 or on our website at *priorityhealth.com.*

See Sections 5.II.A and 5.II.D for the steps of the prior approval process, including how to confirm Coverage before receiving services and supplies.

Prior approval for other services may be requested by you or your provider in order to determine medical/clinical necessity prior to treatment. Prior approval is not a guarantee of Coverage or a final determination of benefits under this plan.

A. Prior Approval Must be Obtained:

At least 5 working days before a non-Medical Emergency admission or procedure, including transplants.

In addition, emergency admissions must be reported to our Health Management Department as soon as reasonably possible after the time of admission.

B. Retrospective Review

If approval in advance is not obtained for those services requiring prior approval, we will review the claim after you receive the services. If we determine that care received was Medically/Clinically Necessary and appropriate, the care will be Covered at the applicable Benefit level with a reduction in benefits as shown on the Schedule of Benefits. If we determine that the care received was not Medically/Clinically Necessary and appropriate, the charges will not be Covered.

C. Re-evaluation of Decision on Prior Approval.

At any time, you or your Physician may ask our Health Management Department (or our Behavioral Health Department in the case of substance abuse services) to re-evaluate our decision on prior approval, or to extend the number of days of Hospital confinement considered Medically/Clinically Necessary for the treatment of a condition. In non-urgent cases, where you ask to extend the number of days of Hospital confinement, we will approve, deny or partially approve your request as soon as reasonably possible, but not later than 24 hours after receipt of the request, provided that you make such a request at least 24 hours prior to the expiration of the prescribed period of time. If the Hospital confinement extends beyond the number of approved days, the additional days will not be Covered unless the extension of days is Medically/Clinically Necessary and we have given approval in advance for the extension before the extension begins.

D. Prior Approval of Certain Health Care Services and Supplies.

As stated in this Section 5.II above, certain services and supplies that Health Professionals recommend or provide to you must receive prior approval from Priority Health before they can be Covered. In most cases, Priority Health will approve, deny or partially approve or partially deny a request for prior approval within 15 days of receipt. However, in urgent cases, the determination period is reduced to 72 hours. In some cases we may ask you for additional information or additional time in which

to make our determination. In all cases, if you obtain services that we say are not Covered, you will be responsible for payment for those services. If you want our decision to be reviewed, you must contact us. Section 10 tells you how to do that.

See Section 5.II.E below for the reduction in benefits that may apply when prior approval is not requested.

E. Reduction of Benefit Payment.

If prior approval is not obtained before you receive any of the services listed in this Section 5.II, we will reduce your level of benefits according to the Schedule of Benefits. We will not apply the reduction in benefits to the Annual Out-of-Pocket Maximum Expense. The amount we pay after taking into account any Copayments, Coinsurance and Deductibles will be reduced even if the Annual Out-of-Pocket Maximum Expense has been reached. The Annual Out-of-Pocket Maximum Expense is shown in the Schedule of Benefits.

III. Covered Services At The Network Benefits Level and The Non-Network Benefits Level.

Covered Services, which may be limited by the Schedule of Benefits , are stated below. For additional Covered Services, please review any Addenda to this policy.

A. Network Benefits.

You are entitled to the Covered Services at the Network Benefit level described in Section 5.IV when those services meet the following criteria:

(1) Medically/Clinically Necessary (as defined in this 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

(2) Routine or Preventive Health Care Services as described in this document; and

(3) Provided by a Network Provider and approved in advance by us when we consider approval necessary (see Sections 5.II.A and 5.II.D for prior approval requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services. See Section 5.II.E. for the reduction in benefits that may apply when prior approval is not obtained.); and

(4) Not excluded elsewhere in this Policy or in an Addendum or Amendment to this Policy. (Note: Payment for Covered Services will not exceed the combined Maximum Annual Benefit per Member for Network and Non-Network Benefits.)

For Network Benefits, you are responsible for those Copayments, Deductibles, and Coinsurance as listed in the Schedule of Benefits with this Policy. Deductibles apply to all Covered Services except as indicated on the Schedule of Benefits.

You are responsible for determining whether a provider is part of the Network before receiving services. Unless otherwise specified in this Policy, benefits will be paid based on the Network status of the provider as of the day that services are received. To verify the current Network status of a provider, contact our Customer Service Department at 800 528-8762 or on our website at *priorityhealth.com.*

B. Non-Network Benefits.

You are entitled to the Covered Services at the Non-Network Benefits level described in Section 5.IV when those services meet the following criteria:

(1) Medically/Clinically Necessary (as defined in this 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

(2) Approved in advance by us when we consider approval necessary (see Sections 5.II.A and 5.II.D for prior approval requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services. See Section 5.II.E. for the reduction in benefits that may apply when prior approval is not obtained.); and

(3) Not excluded elsewhere in this Policy or in an Addendum or Amendment to this Policy.

For payment at the Non-Network Benefits level, the Non-Network Provider must be appropriately licensed to perform the Covered Service provided. You are responsible for those Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary listed in the Schedule of Benefits. Deductibles apply to all Covered Services except as indicated on the Schedule of Benefits. You are also responsible for Charges in excess of Reasonable and Customary Charges.

NOTE: Sometimes a provider may refer you for, or suggest, a service that we do not Cover. Just because a provider refers you, or suggests, the service does not mean you will have Coverage for that service. For example: Acupuncture is excluded from Coverage. If your doctor recommends acupuncture as a treatment for a medical condition, Coverage for acupuncture will not be provided even if acupuncture could prevent the need for more costly Covered Services. Remember – If you receive services that we do not Cover, you must pay for those services.

You should carefully review the rest of this Policy and any Addenda and Amendments for more information about the extent of your Coverage.

IV. Covered And Non-Covered Services

You are responsible for the Copayments, Coinsurance and Deductibles listed in the Schedule of Benefits. Deductibles apply to all Covered Services except certain preventive health care services as described on the Schedule of Benefits. Coverage for preventive health care services is available after a waiting period of 90 consecutive days beginning on Your most recent effective date under this Policy. Preventive health care services are only those services described in Priority Health's preventive health care guidelines. These guidelines are available online at *priorityhealth.com,* or you may request a copy from our Customer Service Department.

Preventive health care services do not include any service or benefit intended to treat an existing illness, injury, or condition. Pre-natal, delivery and post-partum Maternity Care Services are not Covered under this Policy. Complications of a Pregnancy, as defined, are Covered under the terms and conditions of this Policy.

Health Care Services, other than preventive health care services, are subject to the Pre-Existing Condition exclusion described in Section 6 of this Policy.

NOTE: The headings used in Section 5.IV are intended to provide a convenient listing of Covered and Non-Covered Services organized alphabetically within the following categories:

A. Professional Services

B. Pharmacy Services

C. Hospitals, Labs And Other Facilities Services

D. Medical Emergency And Urgent Care Services

E. Durable Medical Equipment (DME) And Supplies

F. Behavioral Health Services

G. Family Planning And Maternity Care Services

H. Dental, Vision And Hearing Services

I. Plan Guidelines

The information following each heading provides a description of *Covered Service* and *Non-Covered Services*, as applicable.

A. Professional Services

1. Preventive Health Care Services

Preventive Health Care Services are described in Priority Health's preventive health care guidelines available in the member center on our website at *priorityhealth.com*, or you may request a copy from our Customer Service Department.

Preventive Health Care Services are Covered Services for each Member even though they are not provided in connection with the diagnosis and treatment of an Illness or Injury. Covered Preventive Health Care Services include:

(a) Immunization (doses, recommended ages, and recommended populations vary)

- Certain vaccines – children from birth to age 18
- Certain vaccines – all adults

(b) Certain Drugs

- Aspirin – men and women of certain ages
- Folic Acid supplements – women who may become pregnant
- Fluoride Chemoprevention supplements – children without fluoride in their water source
- Gonorrhea preventive medication – all newborns
- Iron supplements – children ages 6 to 12 months at risk for anemia

(c) Screening and Counseling Services for Adults

- Abdominal Aortic Aneurysm – men of specified ages who have ever smoked (one-time only)
- Alcohol Misuse – all adults
- Blood Pressure – all adults
- Cholesterol – adults of certain ages or adults at higher risk
- Colorectal Cancer – adults over 50
- Depression – all adults
- Type 2 Diabetes – adults with high blood pressure
- Diet counseling – adults at higher risk for chronic disease
- HIV – all adults at higher risk
- Obesity – all adults
- Sexually Transmitted Infection (STI) – prevention counseling for adults at higher risk
- Tobacco Use – all adults (includes cessation interventions for tobacco users)
- Syphilis – all adults at higher risk

(d) Screening and Counseling Services for Women Only (Including Pregnant Women)

- Anemia – on a routine basis for pregnant women
- Bacteriuria (urinary tract or other infection screening) – pregnant women
- BRCA (counseling about genetic testing) – women at higher risk
- Breast Cancer Mammography – every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention – women at higher risk
- Breast Feeding – interventions to support and promote breast feeding
- Cervical Cancer – sexually active women
- Chlamydia Infection – younger women and other women at higher risk
- Gonorrhea – all women at higher risk
- Hepatitis B – pregnant women at their first prenatal visit
- Osteoporosis – women over age 60 depending on risk factors
- Rh Incompatibility – all pregnant women and follow-up testing for women at higher risk
- Tobacco Use – all women, and expanded counseling for pregnant tobacco users
- Syphilis – all pregnant women or other women at increased risk

(e) Assessments and Screenings for Children

- Alcohol and Drug Use Assessments – adolescents
- Autism Screening – children at 18 and 24 months
- Behavioral Assessments – children of all ages
- Cervical Dysplasia Screening – sexually active females
- Congenital Hypothyroidism Screening – newborns
- Developmental Screening – children under age 3, and surveillance throughout childhood
- Dyslipidemia Screening – children at higher risk of lipid disorders
- Hearing Screening – all newborns
- Height, Weight and Body Mass Index Measurements – children of all ages
- Hematocrit or Hemoglobin Screening – children of all ages
- Hemoglobinopathies or Sickle Cell Screening – all newborns
- HIV Screening – adolescents at higher risk
- Lead Screening – children at risk of exposure
- Medical History – all children throughout development
- Obesity Screening and Counseling – children of all ages
- Oral Health Risk Assessment – young children
- Phenylketonuria (PKU) Genetic Disorder Screening – all newborns
- Sexually Transmitted Infection (STI) Prevention Counseling – adolescents at higher risk
- Tuberculin Testing – children at higher risk of tuberculosis
- Vision Screening – all children

2. Other Provider Care Services

Allergy Testing and Treatments

Covered Services

Allergy testing, evaluations and injections including serum costs.

Non-Covered Services

Skin titration (Rinkle Method), cytotoxicity testing (Bryan's Test), MAST testing, urine autoinjections, bronchial or oral allergen sensitization and provocative and neutralization testing for allergies.

Cancer Drug Therapy

Covered Services

Drugs for cancer therapy and the reasonable cost of administering them are Covered regardless of whether the federal Food and Drug Administration (FDA) has approved the cancer drugs to be used for the type of tumor for which the drugs are being used, as required by state law. Certain drugs may not be Covered if a majority of experts believe that further studies or clinical trials are needed to determine the toxicity, safety or efficacy of the drugs. Limitations apply.

Clinical Ecology and Environmental Medicine

Non-Covered Services

Services and supplies provided to effect changes in or treatment to you and/or your physical environment. "Clinical ecology" and "environmental medicine" means medical practice that is based on the belief that exposure to low levels of numerous common substances in the environment can be responsible for a variety of symptoms affecting numerous body systems.

Diabetic Services, Supplies, and Medications

Covered Services

(a) Blood glucose monitors and diabetes test strips.

(b) Syringes and lancets.

(c) Diabetes educational classes to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition.

(d) Certain diabetic supplies, such as syringes, needles, lancets, and blood glucose test strips, may be purchased at a Network durable medical equipment (DME) provider. Your DME Copayment will apply These supplies may also be purchased at a Network Pharmacy and your prescription drug Coverage will apply after Deductible. See your Schedule of Benefits.

(e) Insulin pumps may be Covered under the DME benefit.

(f) Shoe inserts for Members with peripheral neuropathy, including diabetic neuropathy.

(g) Special shoes prescribed for a person with diabetes when Medically/Clinically Necessary according to the criteria set forth in our medical policies.

Non-Covered Services

(a) Alcohol and gauze pads.

(b) Services and supplies for the convenience of the Member or caregivers.

Dietitian Services

Covered Services

(a) Consultations with a Participating dietitian, upon referral from your PCP, up to a maximum of 6 visits per Contract Year. Dietitian services must be obtained from a dietitian employed by a Network Provider.

(b) See Priority Health's preventive health guidelines for additional dietitian services Covered under Preventive Health Care Services.

Educational Services

Covered Services

Education to manage chronic disease states such as diabetes or asthma.

Non-Covered Services

(a) Maternity classes.

(b) Services for remedial education, including school-based services.

(c) Services, treatment or diagnostic testing related to learning disabilities, cognitive disorders and development delays, and mental retardation.

(d) Education testing or training, including intelligence testing. Testing and evaluations should be requested from and conducted by the child's school district.

(e) Cognitive rehabilitation.

(f) Classes covering such subjects as stress management, parenting and lifestyle changes.

Foot Care

Non-Covered Services

(a) Routine foot care, including corn and callous removal, nail trimming and other hygienic or maintenance care.

(b) Cleaning, soaking, and skin cream application for the feet.

(c) Shoes unless attached to a brace.

Homeopathic and Holistic Services

Non-Covered Services

Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy.

Intractable Pain

Covered Services

Evaluation and treatment of intractable pain.

Outpatient and Inpatient Care

Non-Covered Services

Physician fees and other related charges for certain surgeries and treatments performed on an outpatient or inpatient basis are not Covered. These include but are not limited to bariatric surgery, blepharoplasty of upper lids, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty, surgical treatment of male gynecomastia, certain skin disorder treatments, genetic testing and sleep apnea treatment procedures.

Reconstructive Surgery

Covered Services

(a) Reconstructive surgery to correct Congenital Birth Defects and/or effects of Illness or Injury, if:

(i) The defects and/or effects of Illness or Injury cause clinical functional impairment. "Clinical functional impairment" exists when the defects and/or effects of Illness or Injury:

- causes significant disability or major psychological trauma (psychological reasons do not represent a medical or surgical necessity unless you are undergoing psychotherapy for issues solely related to the Illness or Injury for which the reconstructive surgery is requested),
- interfere with employment or regular attendance at school,
- require surgery that is a component of a program of reconstructive surgery for congenital deformity or trauma, or
- contribute to a major health problem, and

(ii) We reasonably expect the surgery to correct the condition, and

(iii) The services are approved in advance by us and you receive them within two years of the event that caused the impairment, unless either of the following applies:

- The impairment caused by illness or injury was not recognized at the time of the event. In that case, treatment must begin within two years of the time that the problem is identified, or
- Your treatment needs to be delayed because of developmental reasons.

We will Cover treatment to correct the functional impairment even if the treatment needs to be performed in stages as long as that treatment begins within two years of the event causing the impairment and as long as you remain a Member. We will do that even if the treatment takes longer than two years.

Necessary surgery following cancer surgery (such as following a mastectomy) and major trauma (severe lacerations and burns) is a Covered Service as required by law.

(b) Reconstructive Surgery Following Breast Cancer

In compliance with the Women's Health and Cancer Rights Act of 1998, Priority Health will consult with your Physician to determine Coverage for these services:

(i) Reconstruction of the breast on which a mastectomy was performed;

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(iii) Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

The requirement to receive services within two years of the event that caused the impairment does not apply to reconstructive surgery following breast cancer.

Coverage Limitations

Your Coverage for certain procedures, treatments and reconstructive surgeries is limited by the Copayment, Coinsurance and Deductible as shown in the Schedule of Benefits and any Addendum enclosed with this Policy.

Non-Covered Services

Cosmetic services, prescription drugs, treatment, therapies or procedures done primarily to improve the way any part of the body looks. Coverage is excluded for, among other things:

(a) Blepharoplasty of upper or lower lids.

(b) Breast augmentation except when provided as part of post-mastectomy reconstructive services.

(c) Breast reduction.

(c) Chemical peel for acne.

(d) Collagen implants.

(e) Diastasis recti repair.

(f) Excision of lipomas.

(g) Excision of seborrheic keratoses.

(h) Excision of skin tags.

(h) Excision or repair of excess or sagging skin.

(i) Fat grafts, unless an integral part of another Covered procedure.

(j) Hair transplants or repair of any congenital or acquired hair loss, including hair analysis.

(k) Liposuction, unless an integral part of another Covered procedure.

(l) Orthodontic treatment, even when provided along with reconstructive surgery.

(m) Panniculectomy.

(n) Port wine stains and hemangioma treatment.

(o) Removal for excessive hair growth by any method, even if caused by an underlying medical condition.

(p) Rhinoplasty or septorhinoplasty.

(q) Rhinophyma treatment.

(r) Rhytidectomy (wrinkle removal).

(s) Salabrasion.

(t) Scar revision or keloid scar treatment.

(u) Spider vein removal.

(v) Surgical treatment of male gynecomastia.

(w) Tattoo removal.

(x) Treatement of hyperhidrosis.

(y) Treatment of vitiligo.

Rehabilitative Medicine Services

Short-term rehabilitative medicine services are Covered if:

- you receive them as an outpatient or in the home, and
- the services cannot be provided by any federal or state agency or by any local political subdivision, including school districts, when a Member is not liable for the costs in the absence of insurance, and
- the therapy is restorative in nature and there is meaningful improvement within 90 days in the Member's ability to perform functional day-to-day activities that are significant in the Member's life roles.

Covered Services

(a) Physical and occupational therapy including:

(i) spinal manipulations by a chiropractor; and

(ii) all manipulations by osteopathic physicians

for treatment of medical diagnoses are Covered if due to:

- an Injury;
- an Illness; or
- a congenital defect for which you have received corrective surgery.

Biofeedback for treatment of medical diagnoses when Medically/Clinically Necessary, as determined according to our medical policies.

(b) Speech therapy for treatment of medical diagnoses is Covered if due to:

(i) an Injury;

(ii) an Illness; or

(iii) a congenital defect for which you have received corrective surgery.

(c) Cardiac and pulmonary rehabilitation when Medically/Clinically Necessary, as determined according to our medical policies.

The rehabilitative medicine benefits are categorized in the Schedule of Benefits. The maximum benefit per Contract Year for rehabilitative medicine services is shown in the Schedule of Benefits. The maximum applies even when continued care is Medically/Clinically Necessary beyond the maximum benefit.

Note: Rehabilitative medicine services provided in the home are Covered, subject to the Copayments, Coinsurance, Deductibles and visit maximums under the rehabilitative medicine services categories shown in the Schedule of Benefits and not the home health care category.

Non-Covered Services

(a) Therapy is not Covered if there is not meaningful improvement in the Member's ability to perform functional day-to-day activities that are significant in the Member's life roles within 90 days of therapy initiation.

(b) Therapy for the purpose of maintaining physical condition or maintenance therapy for a chronic condition including, but not limited to, cerebral palsy and developmental delays.

(c) Physical, speech or occupational therapy to correct an impairment, when the impairment is not due to Illness, Injury or a congenital defect for which you have received corrective surgery.

(d) Cognitive rehabilitative therapy. Cognitive rehabilitative therapy is defined as neurological training or retraining.

(e) Strength training and exercise programs.

(f) Visual training and sensory integration therapy.

(g) Rehabilitation services obtained from non-Health Professionals, including massage therapists.

(h) Summer programs meant to maintain physical condition or developmental status during periods when school programs are unavailable.

(i) All therapies for developmental delays, cognitive disorders, including physical, occupational, speech, cognitive and sensory integration therapy.

(j) Vocational rehabilitation, including work training, work related therapy, work hardening, work site evaluation and all return to work programs.

(k) Relational, educational and sleep therapy and any related diagnostic testing. This exclusion does not apply to therapy or testing provided as part of a Covered inpatient Hospital service.

(l) Craniosacral therapy.

(m) Prolotherapy.

(n) Services outside the scope of practice of the servicing provider.

Sex Change or Transformation

Non-Covered Services

Any procedure or treatment, including hormone therapy, designed to change your physical characteristics from your biologically determined sex to those of the opposite sex. This exclusion applies despite any diagnosis of gender role or psychosexual orientation problems.

Tobacco Cessation Treatment

Covered Services

Smoking cessation services provided by your Physician.

Non-Covered Services

All related services and supplies for the treatment of tobacco abuse, except for smoking cessation counseling provided by your Physician. (See Priority Health's preventive health care guidelines for tobacco cessation drug treatments Covered under Preventive Health Care Services.)

Transplants

Covered Services

Evaluations for transplants and transplants of the following organs at a facility approved by us, but only when we have approved the transplant as Medically/Clinically Necessary and non-experimental:

(a) Cornea.

(b) Heart.

(c) Lung.

(d) Kidney.

(e) Bone marrow or stem cell.

(f) Liver.

(g) Pancreas.

(h) Small bowel.

We will Cover the following expenses:

(a) Typing or screening of a potential donor only if the person proposed to receive the transplant is a Member and the potential donor is a parent, child or sibling of the Member proposed to receive the transplant.

(b) Computer organ bank searches and any subsequent testing necessary after a potential donor are identified, unless Covered by another health plan.

(c) Donor's medical expenses if the person receiving the transplant is a Member and the donor's expenses are not Covered by another health benefit plan.

(d) One comprehensive evaluation per transplant.

Non-Covered Services

(a) Community wide searches for a donor.

(b) All donor expenses, even those of Members, for transplant recipients who are not Members.

(c) Transplants of artificial organs.

Weight loss services

Non-Covered Services

(a) Medical and surgical treatment of obesity is not Covered under this Policy, even when Medically/Clinically Necessary.

(b) Coverage is excluded for, among other things, weight loss services, supplies, equipment or facilities in connection with weight control or reduction, whether or not prescribed by a physician or associated with an Illness, including, but not limited to: food, food supplements, gastric balloons, certain weight loss surgeries, jaw wiring, liposuction, physical fitness or exercise programs.

B. Pharmacy Services

Cancer Therapy Drugs

Covered Services

Drugs for cancer therapy and the reasonable cost of administering them are Covered regardless of whether the federal Food and Drug Administration (FDA) has approved the cancer drugs to be used for the type of tumor for which the drugs are being used, as required by state law. Certain drugs may not be Covered if a majority of experts believe that further studies or clinical trials are needed to determine the toxicity, safety or efficacy of the drugs.

Injectable Drugs.

Covered 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.

Coverage for injectable and infusible drugs requiring administration in a medical office or outpatient facility by a Health Professional is limited to selected drugs in certain categories. Prior approval by Priority Health is required. Injectable drugs must be obtained at a Network Pharmacy (including Network Specialty Pharmacies for selected drug categories).

Outpatient Prescription Drugs

In general, Covered drugs are treated as outpatient prescription drug benefits when they are obtained at a retail Pharmacy and can be self-administered regardless of the setting. Exceptions to this rule are outlined in our medical policies.

The Schedule of Benefits to your Policy describes the *Covered Services* and *Non-Covered Services* for Outpatient Prescription Drugs under the category **OUTPATIENT PRESCRIPTION DRUG BENEFITS – RETAIL PHARMACY**.

C. Hospitals, Labs, And Other Facilities Services

Note: If a Covered Member receives services at a Network facility, any eligible radiology, anesthesiology, pathology or special diagnostic services will be paid at the Network Benefit. Benefits for provider types other than those listed will be paid based on the provider's Network Status at the time of service.

Ambulatory Surgical Services and Supplies

Covered Services

Outpatient services and supplies furnished by a surgery center along with a Covered surgical procedure on the day of the procedure. Services and tests performed in an outpatient or ambulatory surgical center will be subject to any Copayment, Coinsurance and Deductible applicable to Hospital services.

Home Health Care

Covered Services

Intermittent skilled services, including hospice services, approved in advance by us and furnished in the home by a Home Health Care Agency's registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist or speech therapist. (Hospice services in the home setting do not require prior approval.)

Note: Rehabilitative medicine services provided in the home are Covered, subject to the Copayments, Coinsurance, Deductibles and maximums under the rehabilitative medicine services categories shown in the Schedule of Benefits and not the home health care category.

To qualify for home health benefits, we may require that you meet the following:

(a) Be confined to the home,

(b) Be under the care of a Physician,

(c) Be receiving services under a plan of care established and periodically reviewed by a Physician, and

(d) Be in need of intermittent skilled nursing care or physical, speech, or occupational therapy.

Non-Covered Services

(a) Custodial care. Any care you receive if, in our opinion, you have reached the maximum level of mental and/or physical function and you will not improve significantly more. Custodial and maintenance care includes room and board, therapies, nursing care, home health aides and personal care designed to help you in the activities of daily living and home care and adult day care that you receive, or could receive, from a member of your family. Custodial care is not Covered, even if you receive home health care services or Skilled Services along with custodial care.

(b) Private Duty Nursing.

(c) Residential or Assisted Living. Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aides, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.

Hospice Care

Covered Services

Inpatient and outpatient hospice care is Covered when your Physician informs Priority Health that your condition is terminal and when Medically/Clinically Necessary according to the criteria set forth in applicable medical policies. Inpatient Hospice Care must be approved in advance by us. (Hospice services in the home setting do not require prior approval.)

(a) Inpatient. Short-term inpatient care is Covered when Medically/Clinically Necessary for skilled nursing needs that cannot be provided in other settings. Your Coverage for inpatient hospice care is limited by the Contract Year maximum number of days as shown in the Schedule of Benefits to this Policy.

(b) Outpatient. Outpatient care is Covered when intermittent skilled services by a registered nurse or a licensed practical nurse are required or when medical social services under the direction of a Physician are required.

(c) Respite. Respite care in a facility setting is Covered as outlined in our medical policies.

Non Covered Services

Custodial care is not covered even if you receive inpatient or outpatient hospice care along with custodial care.

Hospital and Longterm Acute Care

Covered Services

(a) Inpatient Care. Hospital and longterm acute inpatient services and supplies including services performed by Health Professionals, room and board, general nursing care, observation care and related services and supplies. Non-emergency inpatient hospital stays must be approved in advance by us.

(b) Outpatient Care. Hospital services and supplies listed under Inpatient Care above that you receive on an outpatient basis.

Non-Covered Services

(a) Pre-natal, delivery and post-partum Maternity Care services are not Covered under this Policy. Complications of a Pregnancy, as defined in Section 16, are Covered under the terms and conditions of this Policy.

(b) Certain surgeries and treatments (including Hospital, Physician and any other related charges) are not Covered as set forth in the Schedule of Benefits to this Policy.

(c) Leave of Absence. Charges incurred when you are on an overnight or weekend pass during an inpatient stay.

Radiology Examinations and Laboratory Procedures

Covered Services

Diagnostic and therapeutic radiology services and laboratory tests not excluded elsewhere in this Section 5.IV.

(a) Certain radiology examinations, including positron-emission tomography (PET scans), magnetic resonance imaging (MRI), computed tomography (CT scans) and nuclear cardiology studies, require prior approval by Priority Health.

(b) Except for certain preventive health care, services and tests may be subject to a Deductible even if the service or test was ordered and performed in a provider's office. See the summary of Preventive Health Care Services in Section 5.IV.A.1. Priority Health's complete preventive health care guidelines are available in the member center on our website at *priorityhealth.com*, or through our Customer Service Department. Pre-natal, delivery and post-partum Maternity Care Services are not Covered under this Policy. Complications of a Pregnancy, as defined in Section 14, are Covered under the terms and conditions of this Policy.

(c) Services and tests performed in a Hospital (either as an inpatient or outpatient) are subject to any Copayment, Coinsurance and Deductible, applicable to Hospital services even if the service or test was ordered and partially performed in a provider's office.

(d) If a Member receives services at a Network facility, any eligible radiology, anesthesiology, pathology or special diagnostic services will be paid at the Network Benefit. Benefits for provider types other than those listed will be paid based on the provider's Network status at the time of service.

Rehabilitative Medicine Services

See. Rehabilitative Medicine Services under Section 5.IV.A above.

Respite Care

Coverage Limitations

Respite care is not covered except when provided by a hospice program for a Member enrolled in a hospice program.

Skilled Nursing Services - Skilled Nursing, Subacute and Inpatient Rehabilitation Facility Care.

Covered Services

(a) Care and treatment, including therapy, and room and board in semi-private accommodations, at a Skilled Nursing, Subacute or Inpatient Rehabilitation Facility when we have approved a treatment plan in advance. The treatment plan will be approved based on our determination of Medical/Clinical Necessity and appropriateness.

(b) Your Coverage is limited by the Contract Year maximum number of days as shown in the Schedule of Benefits to this Policy. The maximum days applies even when continued care is Medically/Clinically Necessary beyond the benefit maximum.

Non-Covered Services

(a) Admission to a Skilled Nursing, Subacute or Inpatient Rehabilitation Facility is not Covered if the necessary care or therapies can be provided safely in a less intensive setting, including the home or a provider office..

(b) Care provided in a facility required to protect you against self-injurious behavior is not Covered. Examples include care in a facility to prevent you from using alcohol or illicit drugs or to insure your compliance with recommended treatment such as medication use, dietary intake or a behavioral care plan.

(c) Custodial care is not Covered, even if you receive skilled nursing services or therapies along with custodial care. Custodial care and services include room and board, therapies, nursing care, home health aids and personal care designed to help you in the activities of daily living and home care and adult day care that you receive, or could receive, from members of your family.

(d) Leave of Absence. Charges incurred when you are on an overnight or weekend pass during an inpatient stay.

D. Medical Emergency and Urgent Care Services

Ambulance Services

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

Covered Services

In a Medical Emergency, we will Cover ambulance service to the nearest medical facility that can provide Medical Emergency care.

We will Cover ambulance transfers between facilities that are approved by us as Medically/Clinically Necessary.

Non-Covered Services

Any other non-emergent transportation is not Covered unless approved in advance by us.

Emergency Care Services and Urgent Care Center Services

A Medical Emergency is the sudden onset of a medical condition with signs and symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, serious impairment of bodily functions or serious dysfunction of any bodily organ or part.

If you are confined in a hospital after a Medical Emergency, you (or someone on your behalf) must let Priority Health know about your confinement as soon as it is reasonably possible to provide that notice.

Services and supplies provided at an Urgent Care Center are Covered. An "Urgent Care Center" is a licensed facility utilized to treat non-life threatening conditions that require immediate medical attention to limit severity and prevent complications.

Covered Services:

- <u>Facility and Provider Services.</u> Services and supplies that you receive for any condition that Priority Health, following our review of the claim and other information, determines to have been a Medical Emergency or required Urgent Care at the time.
- <u>Follow-Up Care.</u> Services you receive from a provider because of a Medical Emergency or Urgent Care situation after the Medical Emergency or Urgent Care situation has ended.

Non-Covered Services

If you use an emergency facility for non-emergent or routine care, you will be responsible for the cost of that care.

E. Durable Medical Equipment (DME) and Supplies

Durable Medical Equipment (DME)

DME is equipment intended for repeated use in order to serve a medical need, is generally not useful to a person in the absence of Illness or Injury, and is appropriate for use in the home. DME over $1,000.00 must be approved in advance by us. Some examples of DME are manual wheelchairs, CPAP machines and glucose monitoring devices. A per Member per Contract Year dollar maximum benefit applies. See the Schedule of Benefits.

Covered Services

(a) DME is Covered by Priority Health when approved in advance by us, when required. For a complete list of Covered DME, go to *priorityhealth.com* or call our Customer Service Department.

(b) Repairs or maintenance of DME required as a result of normal use. We reserve the right to limit replacement of DME to the expected life of the equipment.

(c) Training or education on the use of DME.

(d) Disposable supplies necessary for the proper functioning or application of the DME.

(e) Inhaler assist devices and some diabetic supplies such as syringes, needles, lancets and blood glucose test strips are covered as a DME benefit or as a prescription drug benefit.

(f) Shoe inserts for Members with peripheral neuropathy, including diabetic neuropathy.

(g) Special shoes prescribed for a person with diabetes when Medically/Clinically Necessary according to the criteria set forth in our medical policies.

(h) Shoes when attached to a Medically/Clinically Necessary brace according to criteria set forth in our medical policies.

Coverage Limitations

(a) Coverage is for standard DME only; equipment that is not conventional or not Medically/Clinically Necessary as determined by us or for the convenience of the Member or caregivers will not be Covered. Equipment must be appropriate for home use.

(b) Coverage for DME, including wheelchairs and insulin pumps, is limited to one piece of same-use equipment. Priority Health may substitute one type or brand of DME for another when the items are comparable in meeting your medical needs. Wheelchair Coverage is generally limited to a manually operated wheelchair.

(c) DME may be rented, purchased or repaired. The decision to rent, purchase, repair or replace DME is at our discretion. We will Cover the repair or replacement, fitting and adjustment of Covered DME that is the result of normal use, body growth or body change. We reserve the right to limit replacement of DME to the expected life of the equipment.

Non-Covered Services

(a) Equipment and devices solely for the convenience of you or your caregiver,

(b) The purchase or rental of personal comfort items, convenience items, or household equipment that have customary non-medical purposes, such as, among other things: protective beds, chair lifts, air purifiers, water purifiers, exercise equipment, non-allergenic pillows, mattresses or waterbeds, spas, tanning equipment, and other similar equipment.

(c) Modifications to your home or living area and equipment installation, such as, central or unit air conditioners, escalators, elevators, and swimming pools.

(d) Car seats and modifications to motorized vehicles.

(e) Self-help, communication or adaptive aids, designed for self-assistance or safety. Examples include, among other things, reachers, feeding, dressing and bathroom aids, augmentive communication devices, car seats, and protective beds.

(f) Non-standard items.

(g) Services and supplies not directly related to your care, such as, among other things: guest meals and accommodations, telephone charges, travel expenses, take-home supplies and similar costs.

(h) All repairs and maintenance that result from misuse or abuse.

(j) Replacement of lost or stolen DME.

(k) DME related to certain surgeries and treatments listed on the Schedule of Benefits not Covered under this Policy.

Food, Supplements and Formula

Covered Services

(a) Enteral feedings may be Covered if Medically/Clinically Necessary according to the criteria set forth in our medical policies.

(b) Parenteral nutrition through an IV may be Covered if Medically/Clinically Necessary according to the criteria set forth in our medical policies.

Non-covered Services

All food, formula and nutritional supplements including, but not limited to, infant formula, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements are not Covered, even if approved by the FDA.

Medical Supplies

Covered Services

(a) Medical supplies received while an inpatient or in connection with a home health visit are Covered at your hospital benefit level as set forth in the Schedule of Benefits.

(b) Some medical supplies are Covered under your Durable Medical Equipment Copayment, including such supplies as catheters, syringes, ostomy supplies, feeding tubes, and lancets. For a complete list of Covered items go to *priorityhealth.com* or contact our Customer Service Department.

Non-Covered Services

Certain outpatient medical supplies that are consumable or disposable supplies, including, among other things, gloves, diapers, adhesive bandages, elastic bandages, and gauze.

Prosthetic and Orthotic/Support Devices

Prosthetics and orthotics over $1,000.00, all rentals and all shoe inserts must be approved in advance by us. A per Member per Contract Year dollar maximum benefit applies. See the Schedule of Benefits.

Covered Services

(a) Surgically implanted prosthetic devices, such as replacement hip or heart pacemaker if Medically/Clinically Necessary according to the criteria set forth in our medical policies.

(b) Externally worn prosthetic devices if Medically/Clinically Necessary according the criteria set forth in our medical policies.

(c) Purchased, repaired or replaced prosthetics and orthotics if Medically/Clinically Necessary according to the criteria set forth in our medical policies.

(d) Repairs or maintenance of prosthetic and orthotic/support devices required as a result of normal use.

Non-Covered Services

(a) All repairs and maintenance that result from misuse or abuse.

(b) Appliances that have been lost or stolen.

(c) Prosthetic or orthotic devices that are not conventional, not Medically/Clinically Necessary according to the criteria set forth in our medical policies, or for the convenience of the Member or caregivers.

You may call our Customer Service Department to find out if the Prosthetic or Orthotic/Support Device you need is Covered or go to *priorityhealth.com.*

F. Behavioral Health Services

Mental Health Services

A Mental Health Condition means a clinically significant behavioral or psychological condition or syndrome causing distress, disability or functional impairment, regardless of the cause. Mental or Nervous Conditions include: psychosis, depression, schizophrenia, bipolar affective disorder and other psychiatric illnesses listed in the current Diagnostic and Statistical Manual (DSM) of Mental Disorders of the American Psychiatric Association.

Non-Covered Services

Evaluation, consultation and treatment (in any setting) for a Mental Health Condition, including acute crisis interventions, are not Covered under this Policy. Prescription drugs used primarily to treat mental health disorders are not Covered under this Policy.

Substance Abuse Services

Covered Services

Care is Covered when it is approved in advance by our Behavioral Health Department as Medically/Clinically Necessary.

<u>Except in an emergency, you must call our Behavioral Health Department before receiving treatment. Call our Behavioral Health Department at 616 464-8500 or 800 673-8043 for assistance.</u>

Counseling, medical testing, diagnostic evaluation and prescription drugs for detoxification and treatment of substance abuse are Covered as described below:

(a) Inpatient Detoxification. Detoxification services provided in a 24-hour hospital setting with full nursing and medical care. Generally provided on inpatient subacute, services can also be received on a medical/surgical unit when needed for safety or in the absence of adequate services elsewhere. Services received on a medical/surgical unit are managed jointly by our Behavioral Health and Health Management Departments.

(b) Inpatient Rehabilitation. Care provided at an inpatient facility or subacute level with 24-hour per day medically monitored skilled nursing care following full or partial recovery from acute detoxification symptoms.

(c) Partial Hospitalization. An intensive, non-residential level of service where multidisciplinary, medical and nursing services are required. This care is provided in a structured setting, similar in intensity to inpatient, meeting for more than four hours (and, generally, less than eight hours) daily

(d) Intensive Outpatient Programs. Multidisciplinary, structured services provided at a frequency of up to four hours daily, up to five days per week for the treatment of a substance dependence disorder.

(e) Outpatient Treatment. The least intensive level of service, provided in an office setting from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day.

(f) Outpatient/Ambulatory Detoxification. Detoxification services delivered within a structured program having medical and nursing supervision where physiological consequences of withdrawal have non-life-threatening potential. This is Covered under your medical benefits.

Your Coverage for Substance Abuse Care benefits is shown in the Schedule of Benefits to this Policy.

Non-Covered Services

(a) Residential treatment, institutional care, non-licensed programs, half-way houses or assisted living settings. Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aids, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.

(b) Non-medical ancillary services and inpatient care not received in a Hospital or Substance Abuse Treatment Facility.

(c) Services for nicotine/caffeine abuse or addiction.

(d) Experimental/investigational or unproven treatments and services, including biofeedback, hypnotherapy, neurofeedback and methadone maintenance.

G. Family Planning And Maternity Care Services

Abortions

Non-Covered services

All services and supplies relating to elective abortions.

Contraceptive Medications and Devices

Covered Services

Oral contraceptive medications (birth control pills) are Covered under Pharmacy Services in this Policy. See **Outpatient Prescription Drugs** in Section 5.IV.B.

Non-Covered Services

Non-oral methods of contraceptive management, even if administered by a Physician or dispensed by a Pharmacy, such as:

(a) Transdermal and implantable contraceptives

(b) Diaphragms and IUD's, including measurement

(c) Condoms, foams, jellies or ointments and other drugs or devices available over the counter medications and devices.

Complications of a Pregnancy

Covered Services

Complications of a Pregnancy are Covered as any other Illness under the terms and conditions of this Policy.

"Complications of a Pregnancy" means a condition whose diagnosis is distinct from pregnancy but is adversely affected by pregnancy or is a caused by pregnancy. Examples of such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, hyperemesis gravidarum, pre-eclampsia, and similar medical and surgical conditions of comparable severity. It also includes conditions such as Medically/Clinically Necessary cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. It does not include false labor, occasional spotting, Physician-prescribed rest during a pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Maternity Care Services

Non-Covered Services

Pre-natal, delivery and post-partum Maternity Care services for the mother and well newborn are not Covered under this Policy.

Newborn Care for Injury or Illness

Covered Services

Coverage for a Newborn child's Injury or Illness (including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities) for the first 31 days, including telephone assessment and home visits by a registered nurse within three days after the date of the Newborn's discharge for evaluation of the Newborn. These services are only Covered if Medically/Clinically Necessary.

To continue Coverage for the Newborn beyond the first 31 days, you must properly enroll the Newborn within 31 days after the date of birth. Section 3.A explains the proper enrollment procedures.

Reproductive Services.

Covered Services

Oral contraceptive medications (birth control pills) are Covered under Pharmacy Services in this Policy. See **Outpatient Prescription Drugs** in Section 5.IV.B.

Non-Covered Services

(a) Diagnostic, counseling, and planning services for treatment of the underlying cause of infertility including but not limited to, sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy.

(b) Advice on contraception and family planning, including childbirth education.

(c) Genetic counseling, testing and screening services

(d) Non-oral methods of contraceptive management, even if administered by a Physician or dispensed by a Pharmacy, such as:

- Transdermal and implantable contraceptives
- Diaphragms and IUD's, including measurement
- Condoms, foams, jellies or ointments and other drugs or devices available over the counter medications and devices.

(e) Sterilization procedures such as tubal ligations, tubal obstructive procedures and vasectomy.

(f) Services to reverse voluntary sterilization.

(g) All services and supplies relating to treatments for infertility including, among other things, artificial insemination, in-vitro fertilization, embryo or ovum transfer procedures, any other assisted reproduction procedure, fees to a surrogate parent, prescription drugs designed to achieve pregnancy, harvest preservation and storage of eggs or sperm.

H. Dental, Vision And Hearing Services

1. Dental Services

Non-Covered Services

Dental services are not Covered, including among other things:

(a) Routine dental services not listed in Priority Health's preventive health care guidelines.

(b) Dental x-rays.

(c) Dental surgery, such as root canals and tooth extractions, even when provided in conjunction with other treatment or surgery.

(d) Facility, ancillary and anesthesia services.

(d) Orthodontia and orthodontic x-rays, even when provided in conjunction with other treatment or surgery,

(e) Orthognathic surgery,

(f) Dental prostheses, including implants and dentures and preparation of the bone to receive implants or dentures.

(g) Rebuilding or repair of soft tissues of the mouth or lip except as specifically described below.

(h) Bite splints used for dental purposes or for temporomandibular joint dysfunction or syndrome.

(i) Treatment of congenital dental defects, such as missing or abnormally developed teeth.

(j) Treatment, services and supplies related to periodontal/ inflammatory gum disease.

(k) Dental services required due to accidents.

Oral Surgery

Covered Services

(a) Reduction or manipulation of fractures of facial bones.

(b) Removal of tumors or cysts of the jaw, other facial bones, soft tissues of the mouth, lip, tongue, accessory sinuses, salivary glands, or the ducts.

(c) Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental Injury.

(d) Medical services such as suturing of lacerations required in connection with a dental accident.

Non-Covered Services

(a) Rebuilding or repair for cosmetic purposes.

(b) Orthodontic treatment, even when provided along with oral surgery.

(c) Dental surgery in preparation for implants or dentures, including preparation of the bone, or dental surgery done in connection with any of the Covered Services listed above.

Orthognathic Surgery

"Orthognathic surgery" is defined as oral surgical therapy involving the repositioning (but not removal) of an individual tooth, arch segment, or entire arch, if the surgery is provided along with a course of orthodontic treatment to correct bodily dysfunction.

Non-Covered Services

Orthognathic surgery is excluded from Coverage. The following orthognathic surgery services and any other orthognathic services are excluded from Coverage, even if deemed Medically/Clinically Necessary:

(a) Referral care for evaluation and orthognathic treatment.

(b) Cephalometric study and x-rays.

(c) Orthognathic surgery and post-operative care.

(d) Hospitalization.

(e) Orthodontic treatment, even when provided along with orthognathic surgery.

Temporomandibular Joint Dysfunction or Syndrome

Medical care or services to treat temporomandibular joint dysfunction or temporomandibular joint syndrome resulting from a medical cause or Injury are not Covered. "Temporomandibular Joint Syndrome" or "TMJS" means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction.

Non-Covered Services

(a) Office visits for medical evaluation and treatment.

(b) Specialty referral for medical evaluation and treatment.

(c) X-rays of the temporomandibular joint including contrast studies.

(d) Myofunctional therapy.

(e) Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

(f) Bite splints, orthodontic treatment, or other dental services to treat temporomandibular joint dysfunction or syndrome.

2. Vision Care Services

Covered Services

(a) One vision screening during each Calendar Year to determine vision loss.

(b) Coverage is limited to treatment of medical conditions and diseases of the eye.

Non-Covered Services

(a) Eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses.

(b) Eye exercises, visual training, orthoptics, sensory integration therapy.

(c) Radial keratotomy, laser surgeries and other refractive keratoplasties.

(d) Refractions (tests to determine an eyeglass prescription).

3. Hearing Care Services

Covered Services

Hearing tests and one hearing screening during each Contract Year to determine hearing loss.

Non-Covered Services

(a) Services and supplies related to hearing care, including ear plugs, external BAHA devices, hearing aids and adjustments.

(b) Hearing screenings do not include examinations for hearing aids.

I. Plan Guidelines

Against Medical Advice/Noncompliance

Non-Covered Services

You are not Covered for those services or supplies determined by Priority Health medical committees to be ineffective, unproductive or compromised because:

(a) You have voluntarily discharged yourself against the advice of a provider from a facility where you are receiving treatment,

(b) You have been discharged from a facility because of your noncompliance with treatment, or

(c) You have been noncompliant with treatment directed by your provider and agreed to by you, regardless of service setting.

Priority Health may also deny Coverage of services or supplies when discharging yourself from a facility against medical advice, your being discharged from a facility for noncompliance, or your noncompliance with treatment you and your provider have agreed to in any setting is determined to be a major contributing factor to requiring the follow-up service or supply (e.g., an emergency room visit shortly following your leaving against medical advice from a facility for a related Illness or Injury).

Noncompliance with treatment includes but is not limited to:

(a) Failure to take prescribed medication.

(b) Failure to follow through with outpatient treatment after inpatient or other intensive level of care.

(c) Failure to comply with treatment plans or care contracts between you and a provider or you and us.

Court Ordered Services

Covered Services

We will Cover services ordered by a court according to the terms and conditions of this Policy, only if they are Medically/Clinically Necessary and you have not exhausted your benefits for the Contract Year.

Non-Covered Services

Services required by court order and services required to file or respond to an action with a court, including evaluations and testing, or services required as a condition of parole or probation.

Domestic Violence

Covered Services

Medically/Clinically Necessary treatment, services and supplies for Injuries resulting from domestic violence.

Experimental, Investigational or Unproven Services

Priority Health uses the following criteria when evaluating new technologies, procedures and drugs:

(a) Evidence of clear therapeutic effectiveness when used in the general population as demonstrated in peer-reviewed clinical trials.

(b) Evidence of patient safety when used in the general population.

(c) Evidence that the medical community in general accepts the safety and effectiveness of the service outside of investigational setting.

Evidence of clinical meaningful outcomes.

(d) Evidence that clinically meaningful outcomes can be attained at a reasonable cost.

Non-Covered Services

Any drug, device, treatment or procedure that is experimental, investigational or unproven. A drug, device, treatment or procedure is experimental, investigational or unproven if one or more of the following applies:

(a) The drug or device cannot be lawfully marketed in the United States without the approval of the Food and Drug Administration (FDA) and that approval has not been granted.

(b) An institutional review board or other body oversees the administration of the drug, device, treatment or procedure or approves or reviews research concerning safety, toxicity or efficacy.

(c) The patient informed consent documents describe the drug, device, treatment or procedure as experimental or investigational or in other terms that indicate the service is being evaluated for its safety, toxicity or efficacy.

(d) Reliable Evidence shows that the drug, device, treatment or procedure is:

(i) The subject of on-going Phase I or Phase II clinical trials; or

(ii) The research, experimental study, or investigational arm of on-going Phase III clinical trials; or

(iii) Otherwise under study to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or

(iv) Believed by a majority of experts to require further studies or clinical trials to determine the toxicity, safety, or efficacy of the drug, device, treatment or procedure as compared with a standard means of treatment or diagnosis.

"Reliable Evidence" includes any of the following:

- Published reports and articles in authoritative medical and scientific literature, or technology assessment and cost effectiveness analysis; or
- A written protocol or protocols used by the treating facility or the protocol(s) of another facility studying the same or a similar drug, device, treatment or procedure; or
- Patient informed consent documents used by the treating facility or by another facility studying the same or a similar drug, device, treatment or procedure.

Illegal Acts

Non-Covered Services

Treatment, services and supplies in connection with any Injury or Illness caused by your:

(a) commission of, or attempt to commit, a felony or other serious illegal act; or

(b) engagement in an illegal occupation;

We reserve the right to recover the cost of services and supplies that were initially Covered by us and later determined to be excluded as described in this **Illegal Acts** section.

Not Medically/Clinically Necessary

Services and supplies that we determine are not Medically/ Clinically Necessary according to our 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. If you disagree with us about Medical/ Clinical Necessity, you (or your provider, if you wish) may appeal our determination as described in Section 10. But unless and until we agree with you that the services and supplies will be Covered Services, they will be excluded from Coverage.

If we exclude Coverage because a service or supply is not Medically/Clinically Necessary, that decision is a determination about benefits and not a medical treatment determination or recommendation. You, with a Physician, may choose to go ahead with the planned treatment at your own expense. You have the option to appeal our denial of your claim for Coverage under our inquiry and appeal procedure as set forth in Section 10.

Services Not Covered

Non-Covered Services

(a) Charges for treatment of Injury arising out of ownership, operation, maintenance or use of a Motorized Vehicle as a Motorized Vehicle.

(b) No Legal Obligation to Pay. Any service or supply that you would not have a legal obligation to pay for without this Coverage, including, among other things, any service performed or item supplied by a relative of yours if, in the absence of this Coverage, you would not be charged for the service or item.

(c) No Show Charges. Any missed appointment fee charged by a Network or Non-Network Provider because you failed to show up at an appointment, except in the case of a Medical Emergency.

(d) Third Party Requirements. Services required or recommended by Third Parties, including, but not limited to:

(i) Physical examinations in excess of one per year performed by your Physician,

(ii) Diagnostic services and immunizations related to: getting or keeping a job, getting or keeping any license issued by a governmental body, getting insurance coverage, foreign travel, adopting children, obtaining or maintaining child custody, school admission or attendance and participation in athletics.

(e) Unauthorized Services and Supplies.

(i) Services and supplies that your Physician did not perform, prescribe, or arrange according to the guidelines of this Policy.

(ii) Services and supplies sought solely for the purpose of obtaining benefits under this Policy.

(f) Items or Services Furnished, Ordered or Prescribed by any Provider Included on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities. This list is available on the OIG website at www.hhs.gov/oig.

(g) Treatment in a Federal, State, or Governmental Entity. The following are excluded to the extent permitted by law:

(i) Services and supplies provided in a Hospital owned or operated by any federal, state, or other governmental entity.

(ii) Services and supplies provided for conditions relating to military service, if you are legally entitled to the services and supplies and if you have reasonable access to the services and supplies at a governmental facility.

(iii) Services and supplies provided while in detention or incarcerated in a facility such as a youth home, jail or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment.

NOTE: Complications to non-Covered Services described in this Policy are Covered if they result in a Medical Emergency. Complications of a Pregnancy, as defined in Section 14, are Covered under the terms and conditions of this Policy.

SECTION 6. Limitations

To receive Network benefits, you may only receive services from a Network Provider. Both Network and Non-Network services must be prior approved by Priority Health when required

<u>You may call our Customer Service Department to find out what services require prior approval. After you have applied for prior approval, our Customer Service Department can also inform you if Priority Health has approved the services.</u> All services received must be Medically/Clinically Necessary.

<u>NOTE: Sometimes your physician may refer you for, or suggest, a service that we do not Cover. Just because your physician refers you or suggests the service does not mean you will have Coverage for that service. Remember – if you receive services that we do not Cover, you must pay for the services.</u>

A. 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 age 19.

B. Waiting Periods.

Coverage for preventive health care services is available after a waiting period of 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
- 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.
- Varicose Veins.

C. Benefit Maximums.

Some of the Covered Services described in this Policy are subject to benefit maximums. The benefit maximums may differ for the Network and Non-Network Benefits levels. The Schedule of Benefits and any Addenda to this Policy list those maximums. Once you reach a maximum for a Covered Service, you will be responsible for the cost of additional services received during the Contract Year even when continued care is Medically/Clinically Necessary beyond the benefit maximum. The cost of those additional services will not count toward your Deductible or Out-of-Pocket Maximum.

D. Out-of-Pocket Maximums.

In addition to your Deductible, the total amount of Copayments and Coinsurance that you will pay for certain services may have a limit. This limit is called an Out-of-Pocket Maximum. The Schedule of Benefits and any Addenda to this Policy provide more information about Out-of-Pocket Maximums that may apply to you.

E. Maximum Annual Benefit Per Member for Network and Non-Network Benefits.

The total amount of Network and Non-Network Benefits combined that will be paid for any Member in any one Contract Year under this Policy (the "Maximum Annual Benefit Per Member") is listed in the Schedule of Benefits.

F. Work-Related Illness or Injury.

We will not pay for any expenses incurred because of Illness or Injury arising out of or in the course of gainful employment. This is true whether or not you apply for Worker's Compensation benefits. Coverage under this Policy is not intended to replace, duplicate, or substitute for any Worker's Compensation coverage.

We will not pay for charges for treatment of an Injury received while engaging in any dangerous activity for which compensation or prize money is received including, but not limited to the following:

a) Participating, instructing, demonstrating, guiding, or accompanying others in parachute jumping, hand gliding, bungee jumping, competing with any motorized vehicle, skiing, or horse riding; or

b) Practicing, exercising, conditioning, or other physical preparation for any such compensated activity.

Except for the dangerous activity described above, the limitation for Illness or Injury arising out of or in the course of gainful employment described in this section does not apply to a sole proprietor, partner (or spouse, child, or parent of a partner), or corporate officer (who is an officer and stockholder owning at least 10% of the stock of a corporation that has 10 or fewer

stockholders) if that person has been excluded from Coverage as an "employee" under the Michigan Worker's Compensation Act. If this limitation applies to you, please provide information directly to us.

G. Motorized Vehicle.

We will not pay for Covered Services you receive for treatment of Injury arising out of ownership, operation, maintenance or use of a Motorized Vehicle as a Motorized Vehicle.

H. Reasonable and Customary.

The maximum benefit we will pay for any Covered Services at the Non-Network Benefits level is the Reasonable and Customary Charge as defined in Section 16.

I. Services Received While a Member.

We will only pay for Covered Services you receive while you are a Member and Covered under the Policy. A service is considered to be received on the date on which services or supplies are provided to you. We can collect from you all charges for Covered Services that you receive and we pay for after your Coverage terminated, plus our costs of recovering those charges (including attorney's fees).

Because you lose your eligibility when in detention or incarcerated in a facility such as a youth home, jail or prison or otherwise in the custody of law enforcement officers, services received under such circumstances, or when on release for the sole purpose of receiving treatment, are not Covered. If you are admitted to a Hospital while in custody, the entire inpatient stay will not be Covered.

J. Uncontrollable Events.

A national disaster, war, riot, civil insurrection, epidemic or other event we cannot control may make our offices, personnel or financial resources unable to provide or arrange for the provision of Covered Services. To the extent that happens, we will not be liable if you do not receive those services or if they are delayed. But we will make a good faith effort to see that services are provided, considering the impact of the event.

K. Physical Examinations And Autopsy.

The insurer, at its own expense, shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

L Right to Amend or Terminate Policy.

You do not have any vested right to any current or future benefits under this Policy. Your right to benefits is limited to claims you incur before any of the following occurs: amendment of the Policy, termination of the Policy, expiration of the applicable limitations period, or termination of your participation (including termination of any extension period for which you have properly elected and paid). We may change this Policy and any benefits provided under it at any time. We will promptly notify you of any change or termination.

SECTION 7. Your Rights and Responsibilities

As a Member Covered under this Policy you have the following rights:

- You may receive prompt medical care appropriate for your condition, including emergency care if necessary.
- You may receive information regarding appropriate or medically necessary treatment options, which will enable you to make an informed decision about the treatment you receive, regardless of cost or benefit Coverage.
- You may receive information about us, our services, our providers and your rights and responsibilities.
- You may participate in decisions regarding your health care.
- We will treat you with respect.
- We will protect your privacy.

- We will keep your medical and financial records maintained by us confidential, whether in electronic or written form. We will not disclose information from your medical records without your consent, except when permitted or required by law, in connection with the administration of Priority Health, or for anonymous use in statistical studies and medical research.
- You may inspect your medical records and those of your minor dependents at the office of the proper provider during normal business hours. The provider may limit a parent's or legal guardian's access to a minor's medical records without the minor's consent, as provided by law.
- You may contact us to discuss concerns about the quality of care you have received from a provider.
- You may register a complaint or file an appeal with us, or with the Commissioner of the Office of Financial and Insurance Regulation and/or other appropriate state agency, if you experience a problem with us, or a provider.
- You may initiate a legal proceeding if you experience a problem with us or providers after you have exhausted the appeal process.
- We will notify you in a timely manner if we release personal information about you in response to a court order.
- You may review a summary of Priority Health's annual report, and inspect the full report on file with the Office of Financial and Insurance Regulation.
- You may suggest changes to our Rights and Responsibilities policies for Members.

As a Member you also have the following responsibilities:

- You must read the Policy and accompanying Member materials, and comply with the requirements.
- You must call us with questions.
- You must obtain prior approval from Priority Health for services as noted in this Policy, and comply with the limits of any approval of services.
- You must notify providers in a timely manner if an appointment must be canceled.
- You must pay Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary at the time service is provided.
- You must present your ID Card to the provider before you receive a service.
- You must participate in your health care as much as possible by working to understand your health problems.
- You must follow the treatment goals and other instructions given to you by your provider. You may participate in developing your treatment goals when possible. Priority Health or your providers may ask you to enter into an explicit written agreement setting forth your treatment plan to ensure you understand the instructions.
- You must supply, to the extent possible, information needed by us and health care professionals to provide proper care.
- You must notify providers and us if you have other health insurance coverage.
- You must provide truthful information on your application and in any other information provided to us.
- You must promptly notify us of any change in address.
- You must promptly notify us if your ID card is stolen.
- You must cooperate with us to prevent the unauthorized use of your ID Card and to prevent anyone from obtaining benefits in your place.
- You must treat providers and their staff with respect

SECTION 8. Claims Provisions

I. FOR NETWORK BENEFITS AND NON-NETWORK BENEFITS:

When you receive Covered Services from a Network Provider, you will not be required to pay any amounts except for applicable Copayments, Deductibles, and Coinsurance as shown in the Schedule of Benefits. You will not be required to submit any claim forms for Covered Services received from Network Providers.

Services you receive from Non-Network Providers will be paid at the Non-Network Benefits level. Non-Network Benefits are available worldwide.

See Sections 5.II.A and 5.II.D for the requirements and the steps of the prior approval process, including how to confirm Coverage before receiving services.

A. If You Pay for Covered Services:

When you must pay a health care provider for Covered Services, ask us in writing to be reimbursed for those services. With your request, you must give us proof of payment that is acceptable to us. You must send a bill that shows exactly what services were received, including applicable diagnosis and CPT codes, and the date and place of service. A statement that shows only the amount owed is not sufficient. If you have questions about what to send us, you may call our Customer Service Department.

B. Reimbursement Request Time Limit:

- We ask that you make your request within 60 days of the date you obtained the services. If you do not ask for reimbursement within 60 days, we can limit or refuse reimbursement. But we will not limit or refuse reimbursement if it is not reasonably possible for you to give us proof of payment in the required time, as long as you give us the required information as soon as reasonably possible.
- We will only be liable for a claim or reimbursement request if we receive it within one year after the date you receive the services, unless you didn't submit the claim because you are legally incapacitated.

C. Where to Send Your Bills:

Send your itemized medical bills promptly to us at the address on the back of your ID card.

D. Information May Be Required for Payment:

Before we pay health care providers or reimburse you for services you receive, we may require you to give us more information or documentation to prove they are Covered Services. We will not be liable for a claim or reimbursement request if we ask for additional information from you and you do not respond within 60 days after we request the additional information, unless you didn't submit the additional information or respond to us because you are legally incapacitated. Our right to that information or documentation may be limited by state or federal law.

E. Satisfaction With Benefit Determination:

If you are not satisfied with any benefit determination we have made, you can dispute it under the appeal process. Read Section 10 to find out more about that procedure.

II. PROVISIONS REQUIRED BY MICHIGAN INSURANCE CODE

A. Notice Of Claim.

Written notice of a claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible.

Notice given by or on behalf of the Member or the beneficiary to the insurer at Priority Health Claims Department, P.O. Box 232, Grand Rapids, MI, 49501-0232, or to the address referenced on your ID card, or to any authorized agent of the insurer, with information sufficient to identify the Member, shall be deemed notice to the insurer.

Subject to the qualifications set forth below, if the Member suffers loss of time due to a disability for which indemnity may be payable for at least 2 years, he shall, at least once in every 6 months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the Member or any payment by the insurer due to such claim or any denial of liability in whole or in part by the insurer shall

be excluded in applying this provision. Delay in the giving of such notice shall not impair the Member's right to any indemnity which would otherwise have accrued during the period of 6 months preceding the date on which such notice is actually given.

B. Claim Forms.

We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which a claim is made.

C. Proof Of Loss.

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

D. Time Of Payment Of Claims.

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid weekly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

E. Payment Of Claims.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Member. Any other accrued indemnities unpaid at the Member's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Member.

F. Legal Actions.

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

SECTION 9. Termination of Coverage

A. Termination of Policy.

A Subscriber may terminate the Policy on any day of the month by giving 10 days notice of such termination, either in writing or by calling Customer Service. All Coverage under this Policy will terminate at 11:59 p.m. on the effective date of the termination of this Policy.

If you lose your Coverage, we can collect from you all costs for Covered Services that you received and we paid for after your Coverage terminated, plus our cost of recovering those charges (including attorney's fees).

Grace Period.

A grace period of 10 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

B. Loss of Eligibility.

Your Coverage will terminate if you fail to continue to meet the eligibility criteria listed below. If you lose your eligibility, your Coverage will automatically terminate at 11:59 p.m. on the day the loss of eligibility occurred and we can collect from you the costs of Covered Services that you received and we paid for after your Coverage terminated, plus our cost of recovering those charges (including attorney's fees).

You will lose your eligibility on the earliest to occur of the following:

(1) The date you no longer meet the eligibility criteria listed in Section 2 of this Policy. However, you will not lose your eligibility for medical conditions first diagnosed after the effective date of this Policy.

(2) The end of the month in which you become divorced from the Subscriber, if you were Covered as a Covered Dependent.

(3) The date you turn 26 years of age if you have enrolled as a Covered Dependent because you are the Subscriber's child.

(4) The date you enter the military, naval, or air force of any country or international organization on a full time active-duty basis. Your Coverage will not terminate if you are just participating in scheduled drills or other training that does not last longer than one month in any calendar year.

(5) The date you tr 65 or become eligible for Medicare.

C. Termination For Cause.

(1) We can terminate your Coverage for cause 30 days after we notify you in writing if any of the following happens:

(a) You voluntarily refuse or discontinue a service or treatment plan against the advice of a Network Provider(s) and Priority Health that is essential to your health.

(b) You fail to pay any required premium.

(c) You refuse to cooperate with us as required by the terms of this Policy.

(d) You revoke your consent for us to release information to third parties or to receive information regarding your medical care, if your revocation makes it impossible for us to fulfill our responsibilities under this Policy.

(e) You refuse to comply with treatment plans, including, but not limited to:

(i) Refusal to take prescribed medication.

(ii) Refusal to follow through with outpatient treatment after inpatient or other intensive level of care.

(iii) Repeated substance abuse detoxification.

(2) We can terminate your Coverage for cause immediately if either of the following happens:

(a) We find out you have committed or attempted to commit fraud against us or you have been dishonest with us about some important or material matter, including your responses on the application form. For example, we may terminate your Coverage if we find out you gave us wrong or misleading information about your (or your Dependents') medical conditions, or you let someone else use your ID Card or receive benefits in your place. If we choose, termination can be effective the day you committed the fraud or were dishonest with us. Also, we can collect from you the costs for Covered Services that you received after the effective date of termination and we paid for, plus our cost of recovering those charges (including attorney's fees); or

(b) You act so disruptively that you upset our ordinary operations or those of a provider, including but not limited to verbally or physically threatening us or a provider.

(3) We can terminate your Policy back to the original effective date if we determine that you did not meet the eligibility requirements under Section 2 of this Policy and the application form. We can collect from you the costs for Covered Services that you received after the termination date and we paid for, plus our cost of recovering those charges (including attorney's fees), offset by Premium you paid.

If we tell you we have terminated or will terminate your Coverage, we will terminate your Coverage on the date stated in the notice. If you file an appeal within 30 days, we will reinstate your Coverage until a determination is made under the appeal procedure. (Read Section 10 to learn more about the appeal procedure.) If the Appeal Committee determines that your Coverage should be terminated for cause under this Section, we will again terminate your Coverage back to the date stated in the original termination notice. We will only reinstate your Coverage if your Premium is paid up to that time. If the Appeal Committee determines that your Coverage should be terminated for cause under this Section, we will again terminate your Coverage back to the date stated in the original termination notice. If we terminate your Coverage retroactively, we will refund any Premiums you paid for the period after the termination date, offset by the amount of any Covered Services you received during that period. Also, Priority Health is entitled to reimbursement for any payments made for Covered Services you received after your termination date not offset by Premiums you paid.

Note: If you are still eligible for Coverage under Section 2 of this Policy, we will not terminate your Coverage based on your health or your health care needs. Also, we will not terminate your Coverage just because you used the appeal procedure to file a complaint against us.

D. Reinstatement.

If your Coverage was terminated under this Policy because you no longer meet the Dependent Eligibility requirements described in Section 2.B, you are eligible to apply under a Priority Health Individual plan as a Subscriber.

If your Coverage was terminated under this Policy because you are eligible for or covered under another health plan and you subsequently lose eligibility for or coverage under the other health plan, you are eligible to enroll under a Priority Health Individual plan upon termination of your eligibility for or coverage under the other health coverage.

If your Coverage was terminated under this Policy for any reason other than those stated above, you are not eligible to enroll for Coverage under any Priority Health Individual plan following your date of termination under this Policy.

If any renewal premium is not paid within the time granted you for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy, provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified you in writing of its disapproval of such application.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the Member and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

E. Time Limit on Certain Defenses.

After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such 3-year period.

(The foregoing policy provisions shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial 3-year period, nor to limit the application of sections 3432 (change of occupation), 3434 (misstatement of age), 3436 (other insurance – same insurer), 3438 (insurance with other insurers – provision of service or expense incurred basis), and 3440 (insurance with other insurers) in the event of misstatement with respect to age or occupation or other insurance.)

F. Cancellation:

We may cancel this Policy at any time by written notice delivered to the Subscriber, or mailed to the Subscriber, stating when, not less than 5 days thereafter, the cancellation shall be effective; and after the Policy has been continued beyond its original term the Subscriber may cancel this Policy at any time by written notice delivered or mailed to us, effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, we may retain the pro rata premium for the expired time or $25.00, whichever is greater. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

G. Certificate of Creditable Coverage.

After we are notified of your termination of Coverage, you and/or your Covered Dependent(s) will receive a Certificate of Creditable Coverage that will provide proof of the Coverage you had under the Policy. In addition, you have the right to receive a Certificate of Creditable Coverage if you request one for yourself or your dependent(s) within 24 months after the Coverage terminates. If you become covered by other health insurance, a Certificate of Creditable Coverage may help you to receive the new coverage without a pre-existing condition exclusion or with a shorter exclusion period.

You or your Covered Dependents may request a Certificate of Creditable Coverage by writing or calling Customer Service at:

Priority Health
Customer Service Department, MS FH 5
34505 West Twelve Mile Road
Farmington Hills, MI 48331
800 528-8762
or use our secure e-mail on our website at *priorityhealth.com*.

SECTION 10. Inquiry, Appeal and Expedited Review Procedure

We hope that you are always happy with the services you receive from Priority Health. If you have any questions or concerns, please call our Customer Service department. Our representatives will help you with your problem as quickly as possible.

Here's how to reach Customer Service:

Hours: 7:30 a.m. – 7:00 p.m. Monday through Thursday
9:00 a.m. – 5:00 p.m. Friday
8:30 a.m. – 12:00 p.m. Saturday

Phone: 888 389-6645
616 464-8830

Online: Send us a secure message through our website at *priorityhealth.com.*

If you are not happy with the answers that our representative has provided, you or someone acting on your behalf can send us a formal complaint. This formal complaint is called an appeal. You have two years from the date you learn of a problem to file an appeal with us. You can file an appeal to ask us to change a decision about any of the following:

- Benefits (including services determined to be experimental or investigational or not medically necessary or appropriate)
- Eligibility
- Retroactive rescission of your Policy
- Payment of claims (in whole or in part)
- How we've handled payment or coordination of health care services
- Contracts with our providers
- Availability of care or providers
- Delivery or quality of health care services or
- A decision not in your favor. This may include services that have been reviewed by Priority Health and denied, reduced or terminated. It also may include a slow response to a request for a decision from us.

A. Appeal Process

Here is a summary of the appeal process:

Step 1: Filing an Appeal with Prioirty Health

Contact our Customer Service department to file an appeal with us. Our representatives will ask you to fill out an appeal form to tell us about your complaint. They can help you fill out this form. You can include extra information if you wish.

The members of the Appeal Committee may include Priority Health employees, Priority Health members, local employers that offer Priority Health to their employees and physicians from the Priority Health network. Review by the Appeal Committee always includes an opinion from a doctor for medical issues. The doctor is in the same or related specialty that may treat the medical issue being reviewed.

After we receive your appeal, the Appeal Committee will then review your case. We will tell you the date, time and place where the review will be held. We will give you this information after we receive your request for appeal. We will explain what will happen during the review. You also can be at the review, have someone represent you at the review, or participate in the review by telephone. You will get a copy of the material that will be reviewed by the Appeal Committee free of charge. During the review you or your representative will have the chance to talk to the Appeal Committee.

After this review, the Appeal Committee will make a decision and we will mail you a written response within five full business days of the review.

If services have not been received:

Review must be completed with a final determination made within 30 calendar days after we receive your appeal form. The 30 calendar days do not include any days you or your representative may delay the process.

If services have been received:

Review must be completed with a final determination made within 35 calendar days after we receive your appeal form. The 35 calendar days do not include any days you or your representative may delay the process.

If we receive your appeal form during non-business hours, we count the time of receipt as the next business day.

Our Appeal Committee meets every 14 days. It may meet more often to meet these timeframes.

If you are not happy with the decision, you may ask for an external review through the Michigan Office of Financial and Insurance Regulation (OFIR).

Step 2: External Review

If you ask for a review with OFIR, they will first determine:

- If your request is complete.
- If your request is accepted for external review.

If accepted for external review and your issue is about your health, your request will be assigned to an Independent Review Organization (IRO). You will not pay for any of the costs of the independent review. If your issue is not about your health, OFIR will review and decide your issue itself.

To request an external review, you need to complete the form provided by Priority Health and contact OFIR. This form can also be found on the OFIR website listed below. This must be done no later than four months after you get a notice of a decision not in your favor from Priority Health. If Priority Health does not meet the timeline requirement for Step 1 of the internal appeal process, you may also request a review by OFIR. If you have given Priority Health more time for a decision, you may not request a review until Priority Health has made its decision.

A *Health Care-Request for External Review Form* must be sent to OFIR. This allows Priority Health and doctors to tell OFIR about your personal health information. You may also give other information about your case.

Here's how to contact OFIR:

Office of Financial and Insurance Regulation
Health Plans Division
611 West Ottawa, 3rd Floor
P.O. Box 30220
Lansing, MI 48909-7720
877 999-6442
www.michigan.gov/ofir

OFIR tells Priority Health that they received your request for review. Within five business days, OFIR does a review to decide these things:

- If you or your dependent are or were covered under Priority Health.
- If the services seem to be a covered benefit.
- If you have gone through the Priority Health appeal process (unless it is not required).
- If you have given all the information you would like to be reviewed.
- If you have sent in the necessary form.

When this review is done, OFIR will tell you if your request is complete and if it has been accepted. If accepted, OFIR must:

- Tell you that you may send in additional information within seven business days.
- Tell Priority Health that your review request has been accepted.

If your review is not accepted, OFIR must tell you why. If it is not accepted due to incomplete information, OFIR must send you a letter to tell you what is missing.

If your review request is accepted, an IRO is asked to perform the review and to make a recommendation to OFIR within 14 calendar days.

- OFIR gives the information you sent in to the IRO and to Priority Health.
- You and Priority Health will both receive letters telling the name of the IRO that will do the review. You have seven business days to send additional information to the IRO.
- Within seven business days after the letter, Priority Health must give the IRO any documents or information used to make the decision not in your favor. If Priority Health does not do this in seven business days, OFIR can reverse Priority Health's decision.
- Please note that reviews about medical issues are reviewed by an IRO. Reviews about non-medical contractual issues may be reviewed by the Commissioner of OFIR and/or an IRO.

The IRO looks at:

- Medical records related to the case
- The doctor or health care professional recommendations
- Opinions from similar health care professionals and other documents sent in
- Terms of benefit plan coverage
- Most appropriate practice guidelines
- Clinical review criteria developed by Priority Health that relates to your case

After the review is done:

- The IRO must send a recommendation to the Commissioner of OFIR within 14 calendar days.
- The Commissioner reviews it to make sure it agrees with the terms of coverage.
- The Commissioner tells you and Priority Health of the decision within seven business days after getting the recommendation *[OFIR generally takes longer than seven days to make a decision].*
- If the Priority Health decision is reversed, we must approve coverage or pay claims right away.

B. Priority Health Expedited Review

(Emergency Review)

Priority Health will follow a faster review process when there is an emergency.

We will make a decision within 72 hours (three days) from the time we get your request. This timeline begins when we receive your request. During non-business hours, you can leave a message at 877 954-1035 (toll free) to make a request.

The faster process will be followed when you file a request (verbally or in writing) when the normal time to review your case (Step 1 of the appeal process) would:

- put your life in danger
- interfere with your full recovery, or
- delay treatment for severe pain (must be confirmed by your doctor)

After the expedited review, we will tell you by telephone right after we make the decision. We will also send a letter telling you about the decision within two business days after the decision. If you are not happy with the final decision, you may appeal to OFIR within 10 days after you receive the final decision about your expedited review.

C. State of Michigan Expedited Review

(Emergency External Review)

OFIR will follow a faster review process when there is an emergency.

An expedited review by OFIR may be asked for if:

- Your doctor tells OFIR by phone or in writing that Priority Health's review time would put your life in danger, or would interfere with your full recovery, and
- You have already asked for an expedited review by Priority Health.

Priority Health will provide you with a *Health Care-Request for External Review Form* to start this process. You may also contact OFIR to get this form or get it from OFIR's website.

OFIR's expedited review will be done within 72 hours (three days) from the time OFIR gets it from you.

A *Health Care-Request for External Review Form* must be turned in to OFIR. This allows Priority Health and doctors to tell OFIR about your personal health information. You may also give other information about your case.

Here's what happens at OFIR when you send in your request:

- OFIR tells Priority Health and decides if the request meets the requirements for an expedited external review.
- If accepted, your case is reviewed by an IRO, and they will determine if you need to complete a Priority Health expedited internal review first. If this occurs, it will be sent back to follow the Priority Health process.
- If accepted for an expedited external review, Priority Health must provide all paperwork and information to the IRO within 12 hours after we receive notice.
- The IRO must make a recommendation within 36 hours after getting the request.
- The Commissioner reviews the recommendation from the IRO. The Commissioner makes a final decision within 24 hours after receiving the recommendation.

If the Priority Health decision is reversed, we must approve coverage or pay claims right away.

The Commissioner of OFIR must approve IROs. IROs cannot be owned or controlled by, be subsidiary of or in any way owned or controlled by or exercise control with the health plan; a national, state or local trade association of health benefit plans; or a national, state or local trade association of health care providers.

D. Obtaining Information about the Appeal Procedure.

To obtain a complete copy of our Inquiry, Appeal and Expedited Review Procedure and filing form, or to find out more about your appeal rights, please contact our Customer Service Department.

E. Obtaining Information about your Appeal.

You have the right to receive, free of charge, access to and copies of all documents relevant to a claim denial.

F. Filing a Lawsuit against Priority Health.

You have the right to bring an action for benefits. However, before filing a lawsuit against us, you must complete our appeal procedure as described in this Section 10. In addition, you must file suit no later than three years after the date of service or receiving notice that Coverage for the requested service is denied.

SECTION 11. Subrogation and Reimbursement.

When you receive payment for Covered Services, you assign (or transfer) to us all of your rights of recovery from any third party. These rights of recovery include a right to subrogation (which means that we can stand in your or your estate's shoes and sue a third party directly for an Illness or Injury for which we are providing services) and a right of reimbursement (which means that we have a right to be reimbursed out of any recoveries you or your estate receives in the future or may have received in the past from third parties relating to your Illness or Injury for which we are providing services). These rights include recoveries from tort-feasors, underinsured/uninsured motorist coverage, worker's compensation, other substitute coverage, any other group or non-group policy of insurance providing health and/or accident coverage (including, but not limited to, any insurance policy having to do with payment of medical benefits that result from an automobile accident, and any Addenda or attachments to that policy), or any other right of recovery, whether based in tort, contract, or any other body of law. This assignment is to the fullest extent permitted by law. Our rights of recovery shall not be limited to recoveries from third parties designated for medical expenses, but shall extend to any and all recovered amounts. In the case of both subrogation and reimbursement, we will be permitted to pursue a recovery amount equal to the total amount paid by us, or the cost of services provided by us, as applicable, plus reasonable collection costs, because of an Illness or Injury for which you (or your estate or guardian) have or has a cause of action. You are required, when requested, to acknowledge our rights of recovery in writing. Our right of recovery, however, is not dependent upon this acknowledgement. You must tell us immediately, in writing, about any situation that might let us invoke our rights under this Section.

You must cooperate with us to help protect our rights under this Section. You agree that these rights will be considered the first priority claim with a first priority lien of 100% of the proceeds of any full or partial recovery against anyone else. Our claim will be paid before any other claims are paid, whether or not you have recovered your total amount of damages. We must be reimbursed in full before any amounts (including attorney's fees incurred by you or your guardian or estate) are deducted from the policy proceeds, judgment or settlement.

Neither you, nor anyone acting for you, will do anything to harm our rights under this Section. If you settle a claim or action against a third party, you will be considered to have been made whole by the settlement. We expressly reject the application of any "make whole", common fund or other claim or defense to Priority Health's subrogation or reimbursement rights. We will then have the right to immediately collect the present value of our right to reimbursement, as described above. Our claim will be the first priority claim from the settlement fund. If you receive any proceeds of settlement or judgment, and if we have a right of reimbursement in those proceeds, you must hold those proceeds in trust for us. Transfer of such funds to a third party does not defeat our right of reimbursement if the funds were or are intended for your benefit. We can recover from you expenses we incur because you failed to cooperate in enforcing our rights under this Section.

For purposes of this section, the term "you" includes you and any person claiming through or on behalf of you, including relatives, heirs, assigns and successors.

SECTION 12. Provisions Required by Michigan Insurance Code

(1) Insurance with Other Insurers.

If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of a loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(2) Unpaid Premium.

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

SECTION 13. Non-Duplication of Benefits

The benefits under this Policy are not intended to duplicate any benefits to which Members are, or would be, entitled under any other federal or state government program, nor are they intended to duplicate any "no fault" benefits. All sums payable under such programs or policies for services provided pursuant to this Policy shall be payable to and retained by us. Each Member shall complete and submit to us such consents, releases, assignments and other documents as may be requested by us in order to obtain or assure reimbursement in connection with any governmental program or "no fault" benefits for which Members are eligible.

SECTION 14. Premiums

Premiums for Covered Services to be provided under this Policy are as disclosed to you on our acceptance letter.

The initial Premium will be effective for the initial Contract Year of this Policy. We may change the Premium upon 30 days written notice to you prior to the renewal of this Policy or a change in any applicable law or regulation having a direct and material impact upon the cost of providing Coverage to Members (such as an increase in the premium tax applicable to such Coverage or revision of the Covered Services provided under this Policy to include benefits mandated by applicable laws). You may terminate this Policy as of the date that the revised Premium would become effective, by providing written notice of termination not less than 10 days prior to such effective date.

Premiums are due in full at Priority Health on or before the first day of each month for the following month's Coverage unless arrangements have been made with us to make payments on a quarterly basis. Each Premium period, whether monthly or otherwise, shall end at 11:59 p.m. E.S.T.

Premium payments to Priority Health are subject to a 10-day grace period, during which time Premiums may be made to us without lapse of Coverage. If the Premium is not paid within that grace period, your Coverage will, at our discretion, be terminated as of the end of that period. If you fail to pay the required Premium and Coverage is terminated, we can collect from you all costs of Covered Services that you received and we paid for during the 10-day grace period, plus our costs of recovering these charges (including attorney's fees).

SECTION 15. Renewal

The initial term of this Policy is from 12:01 a.m. of the day Coverage becomes effective and ends at midnight on the last day of the month preceding the month of your effective date in the following year. For example, if your Policy was effective on April 15, it will end on March 31 of the following year. Following the initial term, this Policy will renew automatically for an additional 12 months, subject to all terms and conditions of this Policy, unless otherwise terminated as provided for in this Policy. We will give you advance written notice of any change in the Premium or material changes in Covered Services or other provisions of this Policy that will be effective on the renewal date. Payment of the applicable Premium on and after that date will constitute acceptance of those changes by you, individually and on behalf of all of the Members enrolled under this Policy. You may terminate this Policy as of its renewal date by providing written notice of non-renewal not less than 10 days prior to the renewal date, if such changes are not acceptable to you.

SECTION 16. Definitions

(1) Accident or Accidental. An event that meets all of the following requirements:

- (a) Causes harm to the physical structure of the body;
- (b) Results from an external agent or trauma;
- (c) Is the direct cause of a loss, independent of any disease, bodily infirmity or any other cause;
- (d) Is definite as to time and place; and
- (e) Happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

An Accident does not include harm resulting from an Illness.

(2) Addendum. Attachment to this Policy which specifies additional Covered Services.

(3) Allowable Expense. A necessary, reasonable and customary expense for health care, when the item of expense is Covered at least in part by one or more plans covering the person for whom the claim is made

(4) Amendment. The Policy may be changed at any time; these changes would be reflected in an additional document called an Amendment which would be attached to this Policy.

(5) Balance Billing. Priority Health will pay for services received under your Non-Network Benefits, subject to a limit of the Reasonable and Customary Charges (as defined below). A Non-Network Provider may bill you for amounts in excess of the Reasonable and Customary Charges, as these charges are not Covered by Priority Health.

(6) Behavioral Health Department. The department that assesses and arranges substance abuse services for Members. The department is available for assessment 24 hours a day.

(7) Brand Name Drug**.** A prescription drug that is protected by a patent, supplied by a single company and marketed under the manufacturer's brand name.

(8) Certificate of Creditable Coverage. A Certificate issued to you and/or your Covered Dependents upon termination of Coverage under this Policy.

(9) Child Placed for Adoption. A child of whom the Subscriber has custody and for whom the Subscriber has assumed and retains a legal obligation for partial or total support in anticipation of adoption.

(10) Coinsurance. The portion of Covered health care costs for which the Covered person has a financial responsibility, usually stated as a fixed percentage. Often, Coinsurance applies after first meeting a Deductible requirement.

(11) Complications of a Pregnancy. A condition whose diagnosis is distinct from pregnancy but is adversely affected by pregnancy or is a caused by pregnancy. Examples of such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, hyperemesis gravidarum, pre-eclampsia, and similar medical and surgical conditions of comparable severity. It also includes conditions such as Medically/Clinically Necessary cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. It does not include false labor, occasional spotting, Physician-prescribed rest during a pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

(12) Congenital Birth Defect. A condition that is present at birth.

(13) Contract Year. The period of time that starts on your effective date under this Policy and ends at midnight on the last day of the month preceding your effective date of the following years (the "renewal date").

(14) Copayments. The amount you must pay directly to a provider of Covered Services for those services and supplies; usually this is a flat dollar amount. You must pay this amount when you receive Covered Services. Copayments are listed in the Schedule of Benefits.

(15) Covered Dependent. Any of your dependents: (a) who meet the eligibility requirements set forth in Section 2 of the Policy; (b) who have been enrolled as required by this Policy; and (c) for whom we have been paid all required Premiums.

(16) Covered Services, Coverage, Cover or Covered. Those services and supplies that you are entitled to under this Policy, if they are Medically/Clinically Necessary and you have met all other requirements of this Policy. The Policy and the Schedule of Benefits limit what we will pay for some services and supplies. When we say we will "Cover" a service or supply, this means we will treat the service or supply as a Covered Service.

(17) Deductible. An amount that you must pay before Priority Health will pay for Covered Services under this Policy. Deductibles, if any, are listed on the Schedule of Benefits or any Addendum attached to this Policy.

(18) Disabled or Disability. Under the Social Security Act, you are Disabled or have a Disability if, taking into account your age, education and past work experience, you are unable to perform any substantial gainful activity by reason of a medically determinable physical or mental impairment, or a combination of impairments, which can be expected to result in death or which has lasted or can be expected to last at least 12 consecutive months.

(19) Generic Drug. A prescription drug approved by the Food and Drug Administration (FDA) that is produced and distributed without patent protection and contains the same active ingredient as the Brand Name Drug.

(20) Health Professional. An individual licensed, certified or authorized under state law to practice a health profession.

(21) Home Health Care Agency. An agency or organization that is licensed to provide skilled nursing services and other therapeutic services in an outpatient setting.

(22) Hospice Care. Services for the terminally ill and their families including pain management and other supportive services.

(23) Hospital. An appropriately licensed acute care institution (including a longterm acute care facility) that provides inpatient medical care and treatment for Ill and Injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of Physicians and with 24 hour-a-day nursing and Physician service.

(24) ID Card. The Identification Card you receive from us as evidence of your enrollment with us.

(25) Ill or Illness. A sickness or a disease, including congenital defects or birth abnormalities.

(26) Injury or Injured. Accidental bodily Injury.

(27) Maximum Annual Benefit Per Member. The Maximum Annual Benefit Per Member is the total amount of Network and Non-Network Benefits combined that will be paid out for a Member in any one Contract Year under this Policy.

(28) Maximum Eligible Benefit. A necessary, reasonable, and customary expense for health care or a provider's contracted rate, (minus any Deductibles, Copayments or Coinsurance) when the item of expense is covered at least in part by one or more policies covering the person for whom the claim is made.

(29) Medical Director. A Michigan-licensed Physician we have designated to supervise and manage the medical aspects of our health care delivery system.

(30) Medical Emergency. The sudden onset of a medical condition with signs and symptoms of sufficient severity, including severe pain, 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 of bodily functions, or serious dysfunction of any bodily organ or part.

(31) Medically/Clinically Necessary. The services or supplies needed to diagnose, care for or treat your physical or mental condition. The Medical Director, or anyone acting at the Medical Director's direction, in consultation with your physician, or, for Substance Abuse services, the Behavioral Health Department, determines whether services or supplies are Medically/Clinically Necessary according to Priority Health's medical and behavioral health policies or adopted criteria that have been approved by community physicians and other providers. Medically/Clinically Necessary services and supplies must be widely accepted professionally by Priority Health's network physicians as effective, appropriate, and essential, based upon nationally accepted evidence-based standards.

All of the following are considered not to be Medically/Clinically Necessary:

(a) Those services rendered by a Health Professional that do not require the technical skills of such a provider;

(b) Those services and supplies furnished mainly for the personal comfort or convenience of you, anyone who cares for you, or anyone who is part of your family;

(c) Those services and supplies furnished to you as an inpatient on any day on which your physical or mental condition could safely and adequately be diagnosed or treated as an outpatient;

(d) Any service or supply beyond those services sufficient to safely and adequately diagnose or treat your physical or mental condition; and

(e) An alternative procedure of no demonstrated additional benefit.

(32) Medicare. Title XVIII of the Social Security Act, as amended.

(33) 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.

(34) Member. A person enrolled with us as a Subscriber or Covered Dependent.

(35) Motorized vehicle. A vehicle, including a trailer, operated or designed for operation upon a public highway by power other than muscular power which has more than 2 wheels. Motor vehicle does not include a motorcycle or a moped, as defined in section 32b of the Michigan vehicle code, 1949 PA 300, MCL 257.32b.. Motor vehicle does not include a farm tractor or other implement of husbandry which is not subject to the registration requirements of the Michigan vehicle code pursuant to section 216 of the Michigan vehicle code, 1949 PA 300, MCL 257.216. Motor vehicle does not include an off-road vehicle (ORV).

(36) Network. An organization that contracts with providers to provide discounted services to Members.

(37) Network Benefits. The benefits provided by Priority Health under this Policy when a Member receives Covered Services from a Network Provider.

(38) Network Hospital. A Hospital that contracts with a Network to provide Covered Services to Members.

(39) Network Mental Health Treatment Facility. A Mental Health Treatment Facility that contracts with a Network to provide Covered Services to Members.

(40) Network Pharmacy**.** A Pharmacy that contracts with the pharmacy benefit manager as designated by Priority Health to provide Covered Services to Members. Names of Network Pharmacies can be provided by Customer Service and can be found or on our website at *priorityhealth.com.*

(41) Network Physician. A Physician who contracts with a Network to provide Covered Services to Members.

(42) Network Provider. A Health Professional or other entity that contracts with a Network to provide Covered Services.

(43) Network Substance Abuse Treatment Facility. A Substance Abuse Treatment Facility that contracts with a Network to provide Covered Services to Members.

(44) Newborn. A child 30 days old or younger.

(45) Non-Network Benefits. The benefits provided when a Member uses Non-Network Providers. Benefits are paid according to the Schedule of Benefits to this Policy.

(46) Non-Network Provider. A Health Professional or other entity, including a hospital or outpatient facility, that has not contracted with us to provide Covered Services to Members.

(47) Non-Occupational Illness and Non-Occupational Injury. An Illness or Injury that does not arise out of (or in the course of) any work for pay or profit, and does not in any way result from an Illness or Injury that arose from work for pay or profit. If we obtain proof that you are covered under a Worker's Compensation law or similar law, but you are not covered for a particular Illness or Injury under that law, that Illness or Injury will be considered "non-occupational" regardless of cause.

(48) Out-of-Pocket Maximums. The total amount any Member will pay toward Covered Services as described in the Schedule of Benefits.

(49) Pharmacy. An establishment where prescription drugs are legally dispensed.

(50) Physician. An appropriately licensed physician or surgeon.

(51) Policy. This document that describes your and our rights and duties. It includes the application form, the Schedule of Benefits, and any Addenda, Amendments and attachments to this document.

(52) Pre-Existing Condition. An Illness, 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

(53) Premium. The total payment from Subscriber, to us for Coverage.

(54) Preventive Health Care Services. Routine care described in Priority Health's preventive health care guidelines that are designated to maintain an individual in optimum health and to prevent unnecessary injury, illness or disability. See Section 5.IV.A.1 for the summary of Covered Preventive Health Care Services. Priority Health's complete preventive health care guidelines are available in the Member Center on our website at *priorityhealth.com* or from our Customer Service Department. Our guidelines are based on federal requirements for Coverage of preventive health care services contained in Section 1001 of the Patient Protection and Affordability Act (PPACA) available at *healthcare.gov*.

(55) Primary Care. Medical care received from a Physician practicing in any of the following fields: Family Practice, General Practice, Gynecology, Internal Medicine, Obstetrics & Gynecology, Pediatrics, and Internal Medicine Pediatrics.

(56) Priority Health. Priority Health Insurance Company, the Michigan corporation and licensed insurance company providing benefits under this Policy.

(57) QMCSO. A Qualified Medical Child Support Order is an order meeting certain requirements that is issued by a state court and directs one or both parents to cover a child under his/her health insurance policy.

(58) Reasonable and Customary Charges. Except as otherwise specified in this policy, the maximum benefit Priority Health will pay for Non-Network Providers for any Covered Service is the Reasonable and Customary charge which is the charge for a Covered Service that is the lower of: (a) the provider's usual charge for furnishing the service; and (b) the charge we determine to be the prevailing charge level made for the service or supply in the geographical area where it is furnished. In determining the reasonable charge for a service or supply that is unusual, or not often provided in the area, or provided by only a small number of providers in the area, we may consider things like the complexity of the service, the degree of skill needed, the type or specialty of the provider, the range of services provided by a facility, and the prevailing charge in other areas.

(59) Residential Treatment. 24 hour services provided in a facility where the focus of care is custodial, and inpatient Medically/Clinically Necessary criteria are not met.

(60) Skilled Nursing, Subacute or Rehabilitation Facility. A facility that is appropriately licensed to provide services in lieu of acute care in a hospital, including skilled nursing care and related services, subacute services and short-term rehabilitative therapy on an inpatient basis.

(61) Specialty Care. Medical care received from a Physician practicing in a specialty field other than those listed under Primary Care as defined in this Section of the Policy.

(62) Specialty Drug. Drugs listed in 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.

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

(64) Subscriber. The primary insured who is the addressee on our acceptance letter: (a) who meets all applicable eligibility requirements of the Policy; (b) who has enrolled for Coverage; and (c) who paid us any applicable Premium payments under the Policy.

(65) Substance Abuse Treatment Facility. A Substance Abuse Treatment Facility is a facility that: (a) meets licensing standards; (b) provides a program for diagnosis, evaluation and treatment of substance abuse; (c) prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs; and (d) provides, on its premises, 24 hours a day, detoxification services, infirmary-level medical services or arranges with a Hospital for any other medical services that may be required, supervision by a staff of Physicians, and skilled nursing care by licensed nurses who are directed by a registered nurse.

(66) Urgent Care. Services provided at a licensed facility other than a Hospital emergency room to treat non-life threatening conditions that require immediate medical attention to limit severity and prevent complications.

(67) Urgent Care Center**.** A licensed facility, not including a Hospital emergency room, that provides Urgent Care for the immediate treatment only of an Injury or Illness.

(68) We, us or our. Priority Health Insurance Company.

(69) You, your or yourself. The Member, whether enrolled with Priority Health as a Subscriber or Covered Dependent.

SECTION 17. General Provisions

A. Independent Contractors.

We do not directly provide any health care services under this Policy, and we have no right or responsibility to make medical treatment decisions. Medical treatment decisions may only be made by Health Professionals in consultation with you. We are only obligated under this Policy to provide Members a Network of health care services.

We are responsible for making benefit determinations under this Policy and our contracts with Network Providers. Health Professionals are responsible for making independent medical judgments.

Health Professionals and you may choose to continue medical treatment even if we deny Coverage for those treatments. In such event, you will be responsible for the cost of those treatments. Health Professionals and you may appeal any of our benefit decisions. Any appeal must follow the inquiry and appeal procedure explained in Section 10.

B. Entire Policy.

The Policy, the application form, the Schedule of Benefits, any Addenda, and any Amendments or attachments, is the entire Policy between Subscriber and us. Beginning on the effective date of Coverage, the Policy supersedes all other agreements for health care services and benefits between you and us.

No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

C. Non-assignment.

You may not assign or transfer any of your rights to benefits or services under this Policy, whether as a Subscriber or a Covered Dependent.

D. Conformity with State and Federal Law.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the Member resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Priority Health will also apply this Policy in accordance with federal laws and regulations.

If any part of this Policy does not agree with state or federal laws or regulations, we will change our procedures to agree with the laws and regulations.

E. Clerical Errors.

Clerical errors, such as incorrect transcriptions of effective dates, termination dates, or erroneous mailings, will not change the rights or obligations of you or us under this Policy and will not operate to grant additional benefits to Members, terminate Coverage otherwise in force or continue Coverage beyond the date it would otherwise terminate.

F. Governing Law and Severability.

This Policy will be governed by Michigan law and any applicable federal law. If any provision of this Policy is held to be invalid or unenforceable, the remaining provisions of this Policy will remain in full force and effect.

G. Notices.

Any notice required or permitted under this Policy shall be in writing and shall be considered to have been given on the date when delivered in person; or if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Member's application form or to any more recent address of which the sending party has received written notice.

H. Third Parties.

This Policy shall not confer any rights, remedies, claims or obligations on third parties except as specifically provided in this Policy.

I. Waiver.

In the event a party waives any provision of this Policy, that party will not be considered to have waived that provision at any other time or to have waived any other provision. The failure to exercise any right under this Policy shall not operate as a waiver of such right.

J. High Deductible Health Plan (HDHP).

This Priority Health plan is intended to meet the "High Deductible Health Plan" requirements set forth in Section 223 of the Internal Revenue Code (IRC) and its subsequent notices, revenue rules, revejue procedures and amendments, if any. If any part of this Policy, including the Schedule of Benefits or any addenda, does not conform with the IRC High Deductible Health Plan requirements, we will interpret it to conform to the the IRC High Deductible Health Plan requirements and amend the Policy accordingly

SECTION 18. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to You

Priority Health understands the importance of handling protected health information with care. We are committed to protecting the privacy of our members' health information in every setting. State and federal laws require us to make sure that your health information is kept private.

When you enroll with Priority Health or use services provided by one of the Priority Health plans, your protected health information may be released to Priority Health and by Priority Health. This information is used and disclosed to coordinate and oversee your medical

treatment, pay your medical claims and assist in health care operations. The use and disclosure of your health information ends when your Coverage ends, except to pay for services received relating to the time that you were Covered or for certain health care operations of Priority Health or our providers.

Federal law requires that we provide you with this Notice of Privacy Practices. This Notice states our legal duties and privacy practices regarding your protected health information. It also states your rights under these laws with respect to the use and disclosure of your health information. Priority Health is required by law to follow the terms of the Notice currently in effect.

Use and Release of Your Health Information

The sections below describe the ways Priority Health uses and releases your health information. Your health information is not shared with anyone who does not have a "need to know" to perform one of the tasks below.

- **Treatment**

We may use your health information or disclose it to third parties to coordinate and oversee your medical care. For example, we may use your health information to help you find a doctor or a hospital that can treat your specific health needs.

- **Payment**

We may use your health information or disclose it to third parties to pay for your medical care. For example, we may use your health information when we receive a claim for payment. Your claim tells us what services you received and may include a diagnosis. We may also disclose this information to another insurer if you are covered under more than one health plan.

- **Health Care Operations**

Priority Health may use your health information and disclose it to third parties in order to assist in Priority Health's everyday work activities such as looking at the quality of your care, carrying out utilization review, confirming benefit eligibility, employee training and review processes, monitoring and auditing activities, and Priority Health's business management and general administrative duties. For example, your health information may be released to members of Priority Health's staff to review the quality of care and outcomes. Your health information may also be released to doctors or doctor groups involved in your care to improve patient care.

Other Permitted or Required Uses and Disclosures

Priority Health may also use or release your health information:

- When required by state or federal law and the use or disclosure complies with and is limited to the requirements of such law
- When permitted for law enforcement purposes
- When permitted to be released to government authorities in cases of abuse, neglect or domestic violence (in which case, you will be notified unless the notification would place you at risk of serious harm)
- When permitted for certain public health activities, such as disease control or public health investigations
- When permitted to be released to public health authorities in child abuse and neglect investigations
- When permitted to be released for certain FDA investigations and activities, such as investigations of product defects or to permit product recalls, repairs or replacements
- When permitted to prevent a serious threat to an individual or a community's health and safety
- When permitted by certain court proceedings (either judicial or administrative)
- When permitted for health oversight activities led by governmental agencies and authorized by law
- When permitted to be released about an inmate to a correctional facility, or otherwise permitted for release in law enforcement custodial situations
- When information about a deceased individual is required by a coroner, medical examiner, law enforcement official or funeral director to carry out their legal duties
- When permitted to be released to cadaveric organ, eye or tissue donation and transplant organizations
- For research purposes when the research has been approved by an institutional review board that has reviewed proposals and established protocols to ensure the privacy of your health information

- When authorized by and to the extent necessary to comply with workers' compensation laws
- When permitted for purposes of providing you with treatment alternatives or other health-related benefits and services
- When permitted to be released to the Armed Forces for active personnel
- When permitted to be released to the Veterans Administration for determining if you are eligible for benefits
- When permitted to be released to Intelligence Agencies for national security
- When permitted to be released to the Department of State for foreign services reasons (e.g. security clearance)
- When permitted to be released to Government Agencies for protection of the President

In order to use or disclose your health information in the above ways, Priority Health may have to follow additional state and federal requirements. Also, in some cases, Priority Health may share your information with one of its "business associates," a person or company that provides certain services to Priority Health. In those cases, Priority Health will have a contract with the business associate, as needed. This contract will require the business associate to confirm they will keep your health information private.

Disclosures to Health Plan Sponsors

(This section of the Notice of Privacy Practices applies to group plans only.)

Priority Health may share information with the sponsor of your group plan (your employer) about whether you are enrolled or disenrolled in the plan. Priority Health may also share summary health information with the sponsor. Summary health information has most identifying information (such as your name, your age and address, except for zip code) removed, and provides the sponsor with information about the amount, type and history of claims paid under the sponsor's group health plan. The sponsor may use this information to obtain premium bids for health insurance coverage or to decide whether to modify, amend to terminate the plan. If the sponsor of your group health plan has agreed to follow federal privacy regulations, Priority Health may also share your protected health information to help the sponsor run the group health plan or to seek available subsidies.

Other Uses of Health Information - By Authorization Only

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. Some common examples of when Authorization is typically needed for certain releases of information concern mental health issues, substance abuse issues, prenatal and pregnancy related services, venereal disease or HIV/AIDS and appeals. We can provide you with a Sample Authorization Form.

If you provide us with an authorization to use or release health information about you, you may end that authorization at any time by writing to Priority Health's Compliance Department. (See Contact Information section.) If you end your authorization, we will no longer use or release health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization.

A parent, legal guardian, or properly named patient advocate may represent you and provide us with an authorization (or may end an authorization) to use or release health information about you if you cannot provide an authorization. Court documents may be required to verify this authority.

Confidentiality in all Settings

We have policies and procedures in place that protect the privacy of your information.

- Every employee signs a statement when they are hired that they understand they are required to keep member information private. They also learn about the actions the company will take if the privacy policies are not followed.
- Priority Health has strict control of access to electronic and paper information specific to members. Only those users authorized with a password have access to electronic information. Paper information is stored in secure locations. Access is only given to those who need it to manage care for members or for administrative purposes.

Priority Health tells all third parties with whom we share information about our privacy policies. These third parties must follow our privacy policies unless they have policies of their own equal to ours.

Priority Health reviews our confidentiality policies and procedures every year. Priority Health also reviews how we collect, use, dispose of and disclose your information. Members (or prospective members) and providers have the right to review Priority Health's confidentiality policies and procedures. You may get copies by contacting Priority Health's Compliance Department. (See Contact Information section.)

Your Rights Regarding Your Health Information

You have the following rights:

Right to Inspect and Copy

You have a right to look at and get a copy of health information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. There are other limited circumstances in which we may deny your request to inspect and copy under federal and state law. If you are denied access to health information, you may request that the denial be reviewed.

To inspect and copy health information, contact Priority Health's Compliance Department in writing. (See Contact Information section.)

If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.

Right to Amend

You have the right to request that Priority Health amend any health information (medical or billing) we have about you. However, Priority Health will not amend any record that:

- it did not create (unless there is a reasonable basis to believe that the creator of the information is no longer available to act on the requested amendment)
- is not part of the medical or billing information we have about you
- is not part of information which you would be permitted to inspect and copy
- is determined by Priority Health to be accurate and complete

To request that we amend your health information, you must write to Priority Health's Compliance Department (see Contact Information section) and include a reason to support the change.

Right to Know About Disclosures

You have the right to know when your health information is disclosed to third parties. You can request a list of disclosures going back six years from the date of your request. This list will not include disclosures:

- to carry out treatment, payment or health care operations
- that were made to you
- for national security or intelligence purposes
- to correctional institutions or law enforcement officials
- that were incidental to a use or disclosure that was permitted or required
- that were made with an authorization by the individual
- of a subset of information called a "limited data set"
- that were prior to April 14, 2003

To request a list of disclosures, you must send your request in writing to Priority Health's Compliance Department. (See Contact Information section.) Your request must specify the time period desired. There will be no charge for the first list you request within a 12-month period. There may be a small charge for any further requests. We will let you know of the cost involved and you may choose to stop or change your request at that time before any costs occur.

Right to Request Restrictions

You have the right to request a limit on the health information that we use or disclose about you. We are not required by law to agree to your request. If we do agree to your request for restriction, we will comply with it unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to Priority Health's Compliance Department. (See Contact Information section.) In your request, you must tell us:

- what information you want to limit
- whether you want to limit our use, disclosure or both
- to whom you want the limits to apply

Priority Health will notify you of receiving your request, either in writing or by telephone, of the restrictions Priority Health has put in place.

Right to Request Confidential Communications

Priority Health will agree to any reasonable request asking that you receive information from the health plan by different means or at a different location. For Priority Health to honor this request, you must clearly state that the disclosure of all or part of that information without the change could be a risk to you.

To request confidential communications, you must make your request in writing to Priority Health's Compliance Department. (See Contact Information section.)

Right to a Paper Copy of This Notice

You have the right to a paper copy of Priority Health's current Notice upon request. To obtain a paper copy of this Notice, please call our Customer Service Department. (See Contact Information section.) Otherwise, you may also print a copy of this Notice from our website at priorityhealth.com.

Changes to this Notice

Priority Health has the right to change the terms of this Notice. We have the right to make these changes apply to health information we already have about you as well as any we receive in the future. We will always post a copy of the current Notice on Priority Health's website. You will also receive materially revised Notices within 60 days of their effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Priority Health and/or the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS). To file a complaint with Priority Health, please call or send a written explanation of the issue to Priority Health's Compliance Department. (See Contact Information section.) You will not be penalized for filing a complaint.

Contact Information

If you have any questions or complaints, please contact Priority Health's Compliance Department or Customer Service Department as noted above at:

Compliance Department
Priority Health
1231 East Beltline NE
Grand Rapids MI 49525

616 942-0954
800 942-0954

Customer Service Department
Priority Health
34505 West Twelve Mile Road
Farmington Hills, MI 48331

800 528-8762

If this information is unclear or if you do not understand it, please call Priority Health for assistance at 888 975-8102 (for TDD services, please call 616 464-8485).

This Privacy Practices Notice is effective: April 14, 2003

The term “Priority Health” refers to four corporations: “Priority Health Government Programs, Inc. (a Michigan non-profit corporation), “Priority Health” (a Michigan non-profit corporation), “Priority Health Insurance Company (a Michigan non-profit corporation) and “Priority Health Managed Benefits, Inc.” (a Michigan business corporation).

Priority Health is a registered trademark and is used by the permission of the owner.

Priority Health is an Equal Opportunity Employer.

Filed in Michigan: 2011

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